Date – August 2022

Manual - Child and Family Services Manual, Chapter C, Child Protective Services

Transmittal # - 304

The purpose of this transmittal is to provide new, revised, and clarified guidance for the Child Protective Services Chapter (C) of the Child and Family Services Manual. Unless otherwise stated, the provisions included in this transmittal are effective September of 2022.

Changes to the manual incorporate federal and state laws as well as state regulations into the guidance; clarify existing guidance; and enhance guidance on meeting the safety, permanency, and well-being of children and families. Changes were also made throughout the manual to address grammatical issues or minor clarifications that are not included in the chart below.

This transmittal and manual are available on FUSION at:

https://fusion.dss.virginia.gov/dfs/DFS-Home/Child-Protective-Services/CPS-Guidance

The entire Child Protective Services Manual can be found on the DSS public site at:

https://www.dss.virginia.gov/family/cps/manuals.cgi

Changes to the manual are listed below.

Section(s) Changed	Significant Changes	Reason for Change
1.5.1.2 First three months training requirement	This subsection was revised to add CWS2000.1W Child Protective Services Webinar and CWS2000VLL: Capacity Building Learning Lab Protective to the first three months training requirements if CWS2000.1 Child Protective Services New Worker Guidance Training with OASIS is not available. This subsection was revised to add online course FSWEB1044: Practice Foundations Guidance and Engagement to the first three months training requirements.	This change was prompted by the COVID-19 pandemic and the suspension of in-person training. This change was made to support a kin first culture in Virginia.
1.5.1.3 First 12 months training requirement	This subsection was revised to add CWSE4060: Family Search and Engagement and CWS4080W: Kinship Care in Virginia to the first 12 months training requirements.	This change was made to support a kin first culture in Virginia.

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1.11.5 Documentation of Indian status	This subsection was revised to include guidance on selecting "Indian Status" in the child welfare information system when documenting the steps taken to determine the status of the child.	This change was made to promote consistent documentation of Indian Status across child welfare programs.
2.3.2.1 Asphyxiation and strangulation	This subsection was renamed and revised to add strangulation as a type of physical abuse.	This change was made to clarify the difference between asphyxiation and strangulation. Strangulation is an act of constricting blood flow to a part of the body and asphyxiation is a condition that results from a deficient supply of oxygen to the body. The act of strangulation does not always result in asphyxiation.
2.3.2.7 Poisoning	This subsection was revised to clarify that the caretaker must intend to alter the child's normal physiological function by giving the substance to the child.	This change was made based on feedback from the LDSS that clarity was needed around the caretaker's intentions.
2.3.2.11 Munchausen syndrome by proxy	This subsection was revised to add that Factitious Disorder Imposed on Another is another term for Munchausen syndrome by proxy.	This change was made to support both medical/mental health terminology used in reports from medical and mental health professionals.
2.4.2.2 Inadequate supervision	This subsection was revised to clarify that inadequate supervision includes acts of omission by the caretaker that allow the child access to substances that alter the child's normal physiological functions.	This change was made based on feedback from the LDSS that clarity was needed when caretakers allow children to access substances that alter the child's normal physiological functions.
2.4.2.8 Knowingly leaving a child with a person required to register as Tier III sexual offender	This subsection was renamed and revised to clarify that the sexual offender must be classified as a Tier III sexual offender instead of as a violent sexual offender.	This change was made based on legislation passed (SB 579) during the 2020 session of the Virginia General Assembly.
2.7.1 Statutory definition	This subsection was renamed and revised to provide the updated statutory definition of an abused or	This change was made based on legislation passed (HB1334) during the 2022 session of the

	neglected child.	Virginia General Assembly.
3.3.1.1 Who are mandated reporters?	This subsection was revised to add individuals who engage in the practice of behavior analysis to the enumerated list of mandated reporters in Virginia.	This change was made based on legislation passed (HB 751) during the 2022 session of the Virginia General Assembly.
3.3.1.6 Mandated reporters may make report electronically	This subsection was revised to add a hyperlink to the Mandated Reporter Portal, VaCPS.	This change was made to provide a direct access link to VaCPS.
3.4.3 LDSS shall record all complaints or reports in writing	This subsection was revised to clarify the retention period of invalid reports.	This change was made to mirror the regulation in 22VAC40-705-50A.
3.4.3.2 New report in an in-home services case	This subsection was created to provide guidance to LDSS when a new report of child abuse or neglect is received on an open in-home services case.	This change was made based on feedback from the LDSS, Office of Children's Ombudsman, and Child and Family Service Reviews to promote consistent practice among the LDSS.
3.5 Determine validity of complaint or report	This subsection was revised to include the updated definition of a valid complaint in § 63.2-1508 of the Code of Virginia.	This change was made based on legislation passed (HB 1334) during the 2022 session of the Virginia General Assembly.
3.5.2.2.3 Caretakers in complaints or reports alleging the human trafficking of a child	This subsection was revised to include the updated definition of who may be considered a caretaker in complaints or reports alleging the human trafficking of a child in § 63.2-1508 of the Code of Virginia.	This change was made based on legislation passed (HB 1334) during the 2022 session of the Virginia General Assembly.
3.5.2.2.4 Caretakers in complaints or reports alleging the sexual abuse or sexual exploitation of a child.	This subsection was created to include the expansion of caretaker status in reports involving the sexual abuse or sexual exploitation of a child in § 63.2-1508 of the Code of Virginia.	This change was made based on legislation passed (HB 1334) during the 2022 session of the Virginia General Assembly.
3.5.2.4 Question 4: Does the LDSS have jurisdiction to conduct the family assessment or investigation?	This subsection was revised to include guidance regarding the transferring of referrals between local departments in § 63.2-1508 D of the Code of Virginia. This subsection was revised to add a resolution process for the LDSS when	This change was made based on legislation passed (HB 1334) during the 2022 session of the Virginia General Assembly. This change was made due to continued jurisdictional disputes

	two local departments of jurisdiction cannot agree on jurisdiction.	between local departments.
3.5.2.4.8 LDSS cannot assume jurisdiction if abuse or neglect occurred in another state and the alleged abuser does not reside in Virginia	This subsection was revised to clarify that the LDSS must not assume jurisdiction of a family assessment or investigation if the alleged abuse or neglect occurred in another state and the alleged abuser does not reside in Virginia.	This change was made because prior guidance in this subsection was contradictory to guidance in 3.5.2.4.2.
3.5.4.2 Screening consideration if alleged abuser is deceased	This subsection was revised to provide guidance that the LDSS should proceed with a child death investigation when the alleged abuser or neglector is deceased.	This change was made to support best practices in the field of child death investigations.
3.5.5.1.1 Invalid complaint involving child care or residential facility	This subsection was renamed and revised to provide additional guidance to the LDSS that invalid reports involving child care or residential treatment facilities must also be reported by the LDSS to the proper regulatory authority.	This change was made based on a recommendation from the Office of the Children's Ombudsman.
3.6.3 Report complaints involving Tier III sexual offenders	This subsection was renamed and revised to clarify that the sexual offender must be classified as a Tier III sexual offender instead of as a violent sexual offender.	This change was made based on legislation passed (SB 579) during the 2020 session of the Virginia General Assembly.
3.9.2 CPS Report Placement Chart	This subsection was revised to replace violent sexual offender with Tier III sexual offender.	This change was made based on legislation passed (SB 579) during the 2020 session of the Virginia General Assembly.
4.1.1 Differential response	This subsection was revised to update the response time for R3 and case opening on the CPS Process Chart.	This change was made to align with current CPS guidance.
4.4.4.6 When the alleged victim child is not found	This subsection was revised to provide guidance to the LDSS on how a missing child should be documented in the child welfare information system.	This change was made to promote consistent practice among the LDSS.
4.4.4.8 LDSS must continue periodic checks for missing child	This subsection was revised to provide guidance to the LDSS on how to document in the child welfare information system when a missing	This change was made to promote consistent practice among the LDSS.

	child is not found after 90 days.	
4.4.4.9 If missing child is found	This subsection was revised to clarify that once a missing child is found a new 45 or 60 day time frame will begin for the completion of the investigation or family assessment.	This change was made to align with the 60 day time frame for the completion of family assessments.
4.4.10 Information about the Office of the Children's Ombudsman	This subsection was created to provide guidance to the LDSS on their requirement to provide biological parents, prospective adoptive parents, and foster parents information about the Office of the Children's Ombudsman.	This change was made as a result of legislation (HB 1301) passed during the 2020 session of the Virginia General Assembly.
4.5.6.7.1 Safe sleep environment and practices	This subsection was revised to provide additional guidance to the LDSS on the importance of assessing the sleep environment, sleep practices, and providing safe sleep information to all families with infants and children less than two years of age.	This change was made to support safe sleep best practices and prevent unsafe sleep related child deaths.
4.5.11.1 Safety decision and family partnership meeting	This subsection was revised to clarify that an FPM should be documented in a case when there is an active CPS referral and open case.	This change was made to promote consistent practice among the LDSS.
4.5.15.2 Risk level determines need to convene FPM	This subsection was revised to clarify that an FPM should be documented in a case when there is an active CPS referral and open case.	This change was made to promote consistent practice among the LDSS.
4.6.2 Time frames to complete investigations	This subsection was revised to clarify that the LDSS must ensure the appropriate exception is selected when not completing an investigation within the 45 day time frame.	This change was made to promote consistent practice among the LDSS.
4.6.6 Face-to-face interview with the alleged victim child	This subsection was revised to provide additional guidance on the use of a minimal facts interview when a face-to-face contact with the victim child needs to be completed within the determined response priority and a forensic interview cannot be scheduled within the response priority.	This change was made to support best practices related to the use of Child Advocacy Centers and forensic interviews in child abuse and neglect investigations.

4.6.11.1 Safe sleep environment and practices	This subsection was revised to provide additional guidance to the LDSS on the importance of assessing the sleep environment, sleep practices, and providing safe sleep information to all families with infants and children less than two years of age.	This change was made to support safe sleep best practices and prevent unsafe sleep related child deaths.
4.6.21.1 Safety decision and family partnership meeting	This subsection was revised to clarify that an FPM should be documented in a case when there is an active CPS referral and open case.	This change was made to promote consistent practice among the LDSS.
4.6.25.2 Risk level determines need to convene FPM	This subsection was revised to clarify that an FPM should be documented in a case when there is an active CPS referral and open case.	This change was made to promote consistent practice among the LDSS.
5.4.2 Identify the regulatory agency	This subsection was revised to clarify that the Department of Education now licenses and certifies facilities such as child day centers, licensed and voluntarily registered family day homes.	This change was made as a result of legislation (HB 1012 and SB 578) passed during the 2020 session of the Virginia General Assembly.
6.1 Introduction	This subsection was revised to add information on the importance of child death investigations and a multi-disciplinary approach.	This change is based on best practices in child death investigations.
6.2.1 Report child death to District Office of the Chief Medical Examiner	This subsection was revised to include directives to LDSS to request a written copy of the autopsy report.	This change was made to strengthen existing practices.
6.2.3 Report child death to CPS Practice Consultant	This subsection was renamed and revised to update the name of the CPS Regional Consultant to CPS Practice Consultant. This subsection was revised to include guidance that this notification includes when the death or near-fatality of a child in foster care occurs, even if the death or near-fatality occurs out-of-state or in another jurisdiction. This subsection was revised to change the amount of time from 24 hours to two working days for the completion	These changes were made to strengthen existing practices.

	of the Preliminary Child Fatality/Near-Fatality Information Form and notification to the CPS Program Manager and Commissioner's Office.	
6.3 Investigation of child death	This subsection was revised to include guidance on the importance of conducting joint investigations with law enforcement.	This change was made to enhance existing best practices related to the investigation of child deaths.
6.3.1 CPS Practice Consultant to provide technical assistance	This subsection was renamed and renumbered.	This change was made to support existing practices and support the chronology of child death investigations.
6.3.2 Assessing safety in a child fatality	This subsection was renumbered and guidance was provided on specific safety considerations when investigating a child death. This subsection was revised to provide that guidance that if there are other children under the age of two in the home the LDSS should provide the caretaker with information on safe sleep practices.	These changes were made to support existing practices and support the chronology of child death investigations.
6.3.4 Investigative protocol	This subsection was created to provide detailed information needed to conduct a thorough child death investigation.	This change was made to support best practices of child death investigations.
6.3.5 Death of a child in foster care	This subsection was renumbered, renamed, and revised to provide guidance to the LDSS on immediate notification to the CPS and Foster Care Practice Consultants of a death of child in foster care and potential conflicts of interest.	This change is based on best practices in child death investigations.
6.3.6 Child death case reporting tool	This subsection was renumbered and revised to provide additional guidance to the LDSS on the purpose of the tool, instructional information on completion of the tool, and time frame for tool completion and submission.	This change was made to clarify existing requirements.
6.3.7 Suspension of child death investigations	This subsection was renumbered and revised to provide guidance that the LDSS must submit a written request	This change was made to clarify existing requirements.

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	to the medical examiner to obtain a written copy of the autopsy and document the request in the child welfare information system.	
6.3.8 Notify CPS Practice Consultant of disposition	This subsection was renumbered, renamed, and revised to clarify that the LDSS should consult with the Practice Consult prior to making final disposition and document the results of the autopsy in the child welfare information system. It removes the requirement that the Practice Consultant notify the Program Manager of the final disposition, assessed risk, and criminal charges on child death investigations.	This change was made to clarify existing requirements.
6.4 Local, regional, and state child fatality reviews	This subsection was revised to clarify the importance of a multi-agency, multi-disciplinary process for the review of child deaths.	This change was made to support best practices of child death investigations.
6.4.2 Regional Child Fatality Review Teams	This subsection was revised to clarify that the regional child fatality review team for each respective jurisdiction will review all child fatalities and examine the circumstances of each child's death.	This change was made to clarify existing requirements.
6.4.2.2 Role and responsibilities of CPS	The subsection was revised to provide additional guidance that the CPS worker or current CPS supervisor are responsible for providing vital information to the child review team.	This change was made to clarify existing requirements.
6.4.2.3 Presenting a case for the regional child fatality review meeting	The subsection was renamed and revised to provide additional guidance on how to prepare for presenting a case at a regional review meeting.	This change was made to clarify existing requirements.
6.5.2 Investigation of child death by Children's Ombudsman	This subsection was created to provide guidance on the types of child deaths that can be reviewed by the Office of the Children's Ombudsman and on the mandatory release of information by the LDSS to the Office of the Children's Ombudsman.	This change was made as a result of legislation (HB 1301) passed during the 2020 session of the Virginia General Assembly.

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6.6 Retention of CPS report involving a child death	The subsection was revised to clarify that the LDSS must document the child death in the child welfare information system so that the record is not purged prematurely.	This change was made to clarify existing requirements.
6.8 Appendix B: Near Child Fatalities	This subsection was renumbered from its prior placement as Appendix H.	This change was made for organizational purposes.
6.9 Appendix C: Additional Resources for Child Fatalities	This subsection was renumbered from its prior placement as Appendix C and revised to include links to current resources that support child death investigations.	This change was made for organizational purposes and to support best practices.
6.9.3 Center for Disease Control and Prevention	This subsection was revised to provide the LDSS with resource information for Sudden Unexpected Infant Death.	This change was made to support best practices of child death investigations.
6.10 Appendix D: Sample Letter	This subsection was revised to provide LDSS with a sample notification letter for the medical examiner.	This change was made to support best practices in child death investigations.
9.2.10 Release information to Office of Children's Ombudsman	This subsection was created to provide guidance on the mandatory release of information to the Office of Children's Ombudsman.	This change was made as a result of legislation (HB 1301) passed during the 2020 session of the Virginia General Assembly.
9.7.3 Identify parties with legitimate interest	This subsection was revised to expand the list of persons with a legitimate interest in CPS records.	This change was made as a result of legislation (HB 733 and SB 316) passed during the 2022 session of the Virginia General Assembly.
10.6.2 Initial safety assessment	This subsection was revised to include the applicable safety factors on our current SDM Safety Assessment Tool.	This change was made because we have a revised SDM Safety Assessment Tool.

Questions about this transmittal should be directed to the Regional Protection Practice Consultants:

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INTRODUCTION TO CHILD PROTECTIVE SERVICES

TABLE OF CONTENTS

DRAFT

DRAFT

1

INTRODUCTION TO CHILD PROTECTIVE SERVICES

DRAFT

1.1 Virginia Children's Services Practice Model

The Virginia Children's Service Practice Model sets forth a vision for the services that are delivered by all child serving agencies across the Commonwealth. The practice model is central to decision making; present in all meetings; and in every interaction with a child or family. Guided by this model, the Virginia Department of Social Services (VDSS) is committed to continuously improving services for children and families by implementing evidence based practices, utilizing the most accurate and current data available and improving safety and well-being of children and families. The Practice Model is founded on these principles:

- All children and communities deserve to be safe.
- Practice is family, child, and youth-driven.
- Children do best when raised by families.
- All children and youth need and deserve a permanent family.

- Partnering with others is important to support child and family success in a system that is family-focused, child-centered, and community-based.
- How we do our work is as important as the work we do.

Child Protective Services (CPS) is just one component on a continuum of family services in Virginia that values the strengths of families.

The Code of Virginia authorizes the VDSS to establish the CPS Program. The purpose of CPS is to identify abused and neglected children and to provide services to prevent further abuse and neglect and to strengthen families by enhancing parental capacity to nurture their children in a safe environment. The CPS Program is based on the following assumptions and values:

- CPS is a process that incorporates past, present and future.
- Implicit in the definition of abuse or neglect is the assumption of harm to the child or children, both real and threatened.
- CPS services and interventions should support the family.
- People can and do change, within the limitations of the individual, his or her environment, time and a worker's skills and perception.
- CPS services are available without regard to income.
- CPS services can be provided to children and their families when no formal complaint has been made, but for whom potential or threat of harm exists.

1.2 Legal authority and definitions

Child Protective Services are provided by local departments of social services (LDSS) under the supervision of the VDSS as authorized by § 63.2-1501 et seq. of the Code of Virginia. The Code of Virginia prescribes that each LDSS maintain the ability to receive and respond to reports alleging abuse or neglect of children.

To further clarify and support the Code of Virginia, the State Board of Social Services has promulgated regulations to guide the operation of CPS programs in Virginia.

The VDSS has developed and maintains this chapter within the larger guidance manual to assist the LDSS in administering the CPS program.

The Virginia Administrative Code (VAC) 22 VAC 40-705-10 provides the following definitions.

> "Department" means the Virginia Department of Social Services.
>
> "Local department" means the city or county local agency of social services or department of public welfare in the Commonwealth of Virginia responsible for conducting investigations or family assessments of child abuse or neglect complaints or reports pursuant to § 63.2-1503 of the Code of Virginia.
>
> "Child protective services" means the identification, receipt and immediate response to complaints and reports of alleged child abuse or neglect for children under 18 years of age. It also includes assessment, and arranging for and providing necessary protective and rehabilitative services for a child and his family when the child has been found to have been abused or neglected or is at risk of being abused or neglected.
>
> "Child protective services worker" means one who is qualified by virtue of education, training and supervision, and is employed by the local department to respond to child protective services complaints and reports of alleged child abuse or neglect.

1.2.1 Services for persons with limited English proficiency

Title VI of the Civil Rights Act of 1964 prohibits recipients of federal funding from discriminating against individuals on the basis of race, color, or national origin. This has been interpreted to require meaningful access to information and services for those persons with limited English proficiency. Agencies receiving federal funding are mandated to comply with these requirements. Information is available on the VDSS public website under the State Plan for the Office of Newcomer Services, Attachment 2C or the U.S. Department of Health and Human Services website.

1.2.2 Children of Native American, Alaskan Eskimo or Aleut heritage

Children of Native American, Alaskan Eskimo or Aleut heritage are subject to the Indian Child Welfare Act (ICWA). In the event such a child is in imminent danger and does not live on a reservation where a tribe exercises exclusive jurisdiction, the *Family Services Specialist who specialize in CPS* has the authority to exercise emergency removal of the child. Additional guidance regarding the removal of an Indian child can

be found in Section 4, Family Assessment and Investigation, of this chapter. If a child is removed and placed into foster care, see Section 3 of the VDSS Child and Family Services Manual, Section E. Foster Care.

Although Virginia has no federally recognized Indian reservations, members of federally recognized tribes do reside in Virginia. A list of recognized tribes and List of Indian Child Welfare Act Designates is provided by the U. S. Department of the Interior Bureau of Indian Affairs.

A child is covered by ICWA when the child meets the federal definition of an Indian child. Specifically, the child is an unmarried person under 18 years of age and is either:

- A member of a federally recognized Indian tribe.
- Eligible for membership in a federally recognized tribe and is the biological child of a member of a federally recognized Indian tribe.

Under federal law, individual tribes have the right to determine eligibility and/or membership. However, in order for ICWA to apply, the child shall meet one of the criteria above.

If there is any reason to believe a child is an Indian child and is at risk of entering foster care, the LDSS shall treat that child as an Indian child, unless and until it is determined that the child is not a member or is not eligible for membership in an Indian tribe. Once it has been determined the child is either a member or eligible for membership in a federally recognized tribe, the LDSS shall make active efforts to reunite the Indian child with their family or tribal community (if already in foster care). Active efforts shall begin from the time the possibility arises that a child may be removed from their parent, legal guardian or Indian custodian and placed outside of their custody.

Active efforts are more than reasonable efforts. Active efforts applies to providing remedial and rehabilitative services to the family prior to the removal of an Indian child from his or her parent or Indian custodian, and/or an intensive effort to reunify an Indian child with his/ her parent or Indian custodian.

Examples of active efforts include, but are not limited to:

- Engaging the Indian child, their parents, guardians and extended family members.
- Taking necessary steps to keep siblings together.
- Identifying appropriate services and helping parents overcome barriers.
- Identifying, notifying and inviting representatives of the Indian child's tribe to participate in shared decision-making meetings.
- Involving and using available resources of the extended family, the child's Indian tribe, Indian social service agencies and individual care givers.

An Indian child who is officially determined by the tribe to not be a member or eligible for membership in a federal tribe is not subject to the requirements of ICWA. In instances where ICWA does not apply, but the child is biologically an Indian child, part of a Virginia tribe that is not federally recognized or considered Indian by the Indian community, the LDSS should consider tribal culture and connections in the provision of services to the child.

Additional information is located in Appendix A: Indian Child Welfare Act (ICWA). Specific information related to court proceedings involving an Indian child can be found in Appendix D in Section 8, Judicial Proceedings of this manual.

1.3 CPS guidance manual format

The CPS guidance manual, which is incorporated into the larger VDSS Child and Family Services Manual, is organized in the following order:

Pertinent Code of Virginia sections are cited for easy reference, but usually not quoted verbatim – if it is quoted, it will be indented and denoted with a blue vertical line. The online version of this chapter provides linkages to the Code of Virginia and VAC. Familiarity with and accesses to the laws of Virginia are important to the LDSS, because the CPS program is based on state and federal law.

The federal Child Abuse Prevention and Treatment Act (CAPTA) is one of the key pieces of legislation that guides child protection. CAPTA was signed into law in 1974 (P.L. 93-247). It was reauthorized in 1978, 1984, 1988, 1992, 1996, and 2003, and with each reauthorization, amendments have been made to CAPTA that have expanded and refined

the scope of the law. CAPTA was most recently reauthorized on December 20, 2010 by the CAPTA Reauthorization Act of 2010 (P.L. 111-320, or 42 U.S.C. 5101 et seq.).

The basis for government's intervention in child maltreatment is grounded in the concept of parens patriae—a legal term that asserts that government has a role in protecting the interests of children and in intervening when parents fail to provide proper care. It has long been recognized that parents have a fundamental liberty, protected by the Constitution, to raise their children as they choose. The legal framework regarding the parent-child relationship balances the rights and responsibilities among the parents, the child, and the State, as guided by Federal statutes. This parent/child relationship identifies certain rights, duties, and obligations, including the responsibility of the parents to protect the child's safety and well-being. If parents, however, are unable or unwilling to meet this responsibility, the State has the power and authority to take action to protect the child from harm. Over the past several decades, Congress has passed significant pieces of legislation that support the States' duty and power to act on behalf of children when parents are unable or unwilling to do so.

The VAC has the impact of law for social services departments in Virginia. Regulations are approved by the State Board of Social Services and either restate law or provide clarification.

The two (2) most relevant regulations for CPS are:

- 22 VAC 40-705-10 et seq. Child Protective Services Regulations.
- 22 VAC 40-730-10 et seq. Investigation of Child Abuse and Neglect In Out Of Family Complaints.

CPS guidance will follow the Code of Virginia and regulation to provide further guidance or explanation, if needed. At times, the Code of Virginia or CPS regulation will require no further explanation, so the Code of Virginia may only be cited, or the regulation provided, and no further guidance given. Anything written in italics indicates that it is new with this version of guidance.

Note: this guidance manual is set up to follow a logical sequence based upon how the CPS process proceeds with some generic issues at the beginning and end. There is additional information that supports best practice in the appendices of each section.

Additional information about CPS guidance:

- A transmittal will be issued when new guidance is developed, usually in January and/or July of each year.
- The transmittal itself has two columns – the first column provides the section of guidance that has been revised, and the second column provides a brief description of the guidance revisions.
- Broadcasts advise the LDSS of transmittals reflecting changes and also provide other important, new information. These broadcasts are available on the internal VDSS website.

1.4 CPS guidance development process

CPS guidance is based on the following:

- The Child Abuse Prevention and Treatment Act (CAPTA) is a federal law that lays the foundation for all state CPS programs.
- The Code of Virginia as enacted by the General Assembly builds on federal law and/or addresses issues unique to Virginia.
- The State Board of Social Services approves regulations.
- Best practice may dictate guidance changes.

While most guidance comes from law and regulation, VDSS continually receives input from local agencies. The CPS Advisory Committee is composed of local CPS staff who provide input and recommendations to the VDSS for CPS guidance. The VDSS also obtains information from three Citizens Review panels, which include the State Child Fatality Review Team, the Child Abuse and Neglect Committee of the Family and Children's Trust Fund (FACT), and the Court Appointed Special Advocate/Children's Justice Act (CASA/CJA) Advisory Board.

The state regional CPS consultants provide case consultation and technical assistance to the LDSS, thus providing feedback from each region of the state. Check with your supervisor to determine how to access these consultants.

All CPS regulations are periodically reviewed and amended based on changes to the Code of Virginia as well as public comment. The VDSS issues a broadcast to announce the review of CPS regulations and the public comment period.

1.5 Uniform training plan for *Family Services Specialist who specialize in CPS*

The VAC mandates uniform training requirements for *Family Services Specialists and Family Services Supervisors who specialize in CPS*. The uniform training requirements establish minimum standards for all *Family Services Specialist and Family Services Supervisors who specialize in CPS* in Virginia.

Having established core (fundamental and essential) competencies for both workers and supervisors, the resulting required training reflects both core competencies and critical training in guidance and law that is specific to the certain practice issues. The result is that all child welfare staff is trained in the same core competencies.

> (22 VAC 40-705-180 A). The department shall implement a uniform training plan for child protective services workers and supervisors. The plan shall establish minimum standards for all child protective services workers and supervisors in the Commonwealth of Virginia.
>
> (22 VAC 40-705-180 B). Workers and supervisors shall complete skills and policy training specific to child abuse and neglect investigations and family assessments within the first two years of their employment.
>
> (22 VAC 40-730-130). Requirements: A. In order to be determined qualified to conduct investigations in out of family settings, local CPS staff shall meet minimum education standards established by the department including: 1. Documented competency in designated general knowledge and skills and specified out of family knowledge and skills; and 2. Completion of out of family policy training.

1.5.1 Training requirements for *Family Services Specialists and Family Services Supervisors who specialize in CPS*

All CPS staff hired after March 1, 2013, who are designated to respond to reports of child abuse and neglect; manage or supervise CPS, shall complete the following as soon as possible after their hire date, but no longer than within the time frames put forth below. Any course designated with a CWSE indicates an e-learning course and is available online in the Virginia Learning Center (VLC).

1.5.1.1 First three weeks training requirements

The following **on-line courses** are required to be completed within the **first three weeks of employment** and are prerequisites for other CPS mandated courses:

- CWSE1002: Exploring Child Welfare (This course is available in the VLC.)
- CWSE1500: Navigating the Child Welfare Automated Information System: OASIS (This course is available in the VLC.)
- CWSE5692: Recognizing and Reporting Child Abuse and Neglect – Mandated Reporter Training (This course is available on the VDSS public website.)

1.5.1.2 First three months training requirement

The following instructor led course is required to be completed within the first three months of employment:

- CWS2000.1: Child Protective Services New Worker Guidance Training with OASIS.
  - Prerequisites: CWSE1002, CWSE150O-CPS, CWSE5692.

The following virtual courses are required to be completed within the first three months of employment if CWS2000.1 is not available:

- *CWS2000.1W: Child Protective Services New Worker Webinar.*
  - *Prerequisites: CWSE1002, CWSE150O-CPS, CWSE5692.*
- *CWS2000VLL: Capacity Building Learning Lab Protective.*

The following online courses are required to be completed within the first three months of employment:

- CWSE1510: Structured Decision Making in Virginia (This course is available in the VLC).
- CWSE5011: Case Documentation (This course is available in the VLC).

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- *FSWEB1044: Practice Foundations Guidance and Engagement (This course is available in the VLC).*

1.5.1.3 First 12 months training requirement

The following Instructor led courses are required to be completed no later than within the first 12 months of employment:

- CWS1021: The Effects of Abuse and Neglect on Child And Adolescent Development.
- CWS1041: Legal Principles in Child Welfare Practice.
  - Prerequisites: CWSE1041 and SCV: Child Dependency Case Processing in JDR District Courts.
- CWS1061: Family Centered Assessment.
  - Prerequisites: CWSE1001, CWSE5692, CWSE1500-CPS, CWS2000.1/CWS2001R.
- CWS1071: Family Centered Case Planning.
  - Prerequisites: CWSE1002, CWSE5692,CWSE1500-CPS, CWS2000.1/CWS2001R.
- CWS1305: The Helping Interview.
- CWS2011: Intake Assessment and Investigation.
  - Prerequisites: CWSE1002, CWSE5692,CWSE1500-CPS, CWS2000.1/CWS2001R.
- CWS2021: Sexual Abuse.
  - Prerequisites: CWSE1002, CWSE5692,CWSE1500-CPS, CWS2000.1/CWS2001R.
- CWS2031.1: Sexual Abuse Investigation.
  - Prerequisites: CWSE1002, CWSE5692,CWSE1500-CPS, CWS2000.1/CWS2001R, CWS2021.

DRAFT

- CWS4020: Engaging Families and Building Trust-Based Relationships.
  - Prerequisites: CWSE1002, CWSE5692,CWSE1500-CPS, CWS2000.1/CWS2001R, CWS2021.
- *CWS4080W: Kinship Care in Virginia*
  - *Prerequisites: CWSE4060*
- CWS5011: Case Documentation
  - Prerequisites: CWSE5011
- CWS5307: Assessing Safety, Risk and Protective Capacity.
  - Prerequisites: CWSE1002, CWSE5692,CWSE1500-CPS, CWS2000.1/CWS2001R.

The following online courses are required to be completed within the first 12 months of employment:

- CWSE4000: Identifying Sex Trafficking in Child Welfare.
- *CWSE4060: Family Search and Engagement*
- CWSE6010: Working with Families of Substance Exposed Infants Modules 1 and 2.

1.5.1.4 First 24 months training requirement

The following instructor led courses are required to be completed no later than within the first 24 months of employment:

- CWS1031: Separation and Loss Issues in Human Services Practice.
- DVS1001: Understanding Domestic Violence.
- DVS1031: Domestic Violence and Its Impact on Children.
  - Prerequisite: DVS1001.

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- CWS2141: Out of Family Investigation (if conducting out of family investigations pursuant to 22 VAC 40-730-130.)
    - Prerequisites: CWSE1002, CWSE5692,CWSE1500-CPS, CWS2000.1/CWS2001R.
- CWS4015: Trauma-Informed Child Welfare Practice: Identification and Intervention.
    - Prerequisite: CWSE4015
- CWS5305: Advanced Interviewing: Motivating Families for Change.

The following online course is required to be completed within the first 24 months of employment:

- CWSE4015: Introduction to Trauma-Informed Child Welfare Practice.

1.5.1.5 Additional training requirement for *Family Services Supervisor who specializes in CPS*

In addition to the courses listed below, all *Family Services Supervisors who specialize in CPS* hired after March 1, 2013 are required to attend the Family Services CORE Supervisor Training Series: SUP5701, SUP5702, SUP5703, SUP5704, and SUP5705. These courses are to be completed in the first two years of employment as a supervisor.

1.5.1.6 Training requirements for *in-home services staff*

See *Section 1, Prevention Overview* for training requirements for workers and supervisors who provide *in-home services*.

1.5.2 Annual training requirements

> (22VAC40-705-180 C) All child protective services workers and supervisors shall complete a minimum of 24 contact hours of continuing education or training annually. This requirement begins after completion of initial training mandates.

Family Services Specialists and Family Services Supervisors who specialize in CPS are required to attend a minimum of 24 contact hours of continuing education/training annually. For those *Family Services Specialists and Family Services Supervisors who*

specialize in CPS hired on or after March 1, 2013, the first year of this requirement should begin no later than 3 years from their hire date, after the completion of the initial training detailed above.

Continuing education/training activities to be credited toward the 24 hours should be pre-approved by the LDSS supervisor or person managing the CPS program. Continuing education/training activities may include, but are not limited to: on-line and classroom training offered by VDSS, organized learning activities from accredited university or college academic courses, continuing education programs, workshops, seminars and conferences.

Documentation of continuing education/training activities is the responsibility of the LDSS.

1.5.3 LDSS must ensure worker compliance

It is the responsibility of the LDSS to ensure that staff performing CPS duties within their agency has met the minimum standards. The *Family Services Supervisor who specializes in CPS* or the person managing the CPS program at the local level shall maintain training documentation in the worker's personnel record. The supervisor shall assure that the *Family Services Specialist who specialize in CPS* and who report to them complete the required training within the given timeframes.

A Training Job Aide is located on the DSS internal website and may be used by the LDSS to document and track all training requirements.

1.5.3.1 Training and direct supervision of new worker for sexual abuse investigations

Effective July 1, 2014 § 63.2-1505D of the Code of Virginia requires direct supervision of *Family Services Specialist who specialize in CPS*s who conduct sexual abuse investigations unless they have completed CWS 2021: Sexual Abuse and CWS 2031.1: Sexual Abuse Investigations. Direct supervision requires a close review of all decisions made during the investigation by someone who has completed the required training. Only persons who have completed the required training may determine the final disposition of a sexual abuse investigation.

1.5.4 Training for staff not designated as *Family Services Specialist who specialize in CPS*

The following course must be completed by local service workers who provide intake functions or respond to reports of abuse or neglect only during nights or weekends while "on call" and were hired after July 1, 2017:

- CWS 2020: On Call for Non-CPS Workers.
    - Prerequisite: CWSE2020: On Call for Non-CPS Workers.

1.6 Multidisciplinary teams

Child Protective Services are best provided in the context of community-based collaboration and support. The Code of Virginia § 63.2-1503 J provides the statutory authority for the LDSS to develop multidisciplinary teams. 22 VAC 40-705-150 E provides regulatory authority for an LDSS to support the development of multidisciplinary teams.

> (22 VAC 40-705-150 E). Local departments shall support the establishment and functioning of multidisciplinary teams pursuant to § 63.2-1503 J of the Code of Virginia.

The purpose of multidisciplinary teams shall be to promote, advocate, and assist in the development of a coordinated service system directed at the early diagnosis, comprehensive treatment, and prevention of child abuse and neglect. It is the responsibility of the Director of the LDSS to foster the creation and coordination of multidisciplinary teams either personally or through his designee. Functions of multidisciplinary teams shall include:

- Identifying abused and neglected children.
- Coordinating medical, social and legal services for the children and their families.
- Helping to develop innovative programs for detection and prevention of child abuse and neglect.
- Promoting community concern and action in the area of child abuse and neglect.
- Disseminating information to the general public with respect to the problem of child abuse and neglect and the facilities and prevention and treatment methods available to combat abuse and neglect.

1.6.1 Composition of multidisciplinary teams

The VAC provides the regulatory framework for the composition of multidisciplinary teams:

> (22 VAC 40-705-10). "Multidisciplinary teams" means any organized group of individuals representing, but not limited to, medical, mental health, social work, education, legal and law enforcement, which will assist local departments in the protection and prevention of child abuse and neglect pursuant to § 63.2-1503 J of the Code of Virginia. Citizen representatives may also be included.

1.6.2 Family assessment and planning teams

The Code of Virginia § 63.2-1503 J also provides that family assessment and planning teams established by a locality may be considered multidisciplinary teams.

1.6.3 Investigation consultation by multidisciplinary teams

The Code of Virginia § 63.2-1503 K allows multidisciplinary teams to provide consultation and assistance in conducting investigations. Multidisciplinary teams can provide better coordination between the professionals who are involved in complicated and serious CPS investigations to help avoid repeated interviews of a child.

1.6.4 Cooperation and exchange of information between the LDSS and multidisciplinary teams

The Code of Virginia § 63.2-1503 J establishes statutory authority for the LDSS to develop agreements that govern the work of the multidisciplinary teams including the exchange of information among team members. LDSS are encouraged to develop written protocols for the operation of local multidisciplinary teams.

Multidisciplinary teams involved in case consultation can have access to confidential case information. All members of a multidisciplinary team abide by laws and policies related to confidentiality. More information about confidentiality and CPS can be found in Section 9, Confidentiality, of this manual.

1.6.5 Multidisciplinary teams for sexual abuse

Section 15.2-1627.5 of the Code of Virginia requires the Commonwealth Attorney to establish a multidisciplinary child sexual abuse response team. These teams will conduct regular reviews of new and ongoing reports of felony sex offenses against a

child. At the request of any team member they can review other child abuse and neglect offenses. The law provides a list of team members to include the Commonwealth Attorney, law enforcement and CPS at the minimum. The team may include a Child Advocacy Center representative, where available.

> (§ 15.2-1627.5 of the Code of Virginia). Coordination of multidisciplinary response to child sexual abuse.
> A. The attorney for the Commonwealth in each jurisdiction in the Commonwealth shall establish a multidisciplinary child sexual abuse response team, which may be an existing multidisciplinary team. The multidisciplinary team shall conduct regular reviews of new and ongoing reports of felony sex offenses in the jurisdiction involving a child and the investigations thereof and, at the request of any member of the team, may conduct reviews of any other reports of child abuse and neglect or sex offenses in the jurisdiction involving a child and the investigations thereof. The multidisciplinary team shall meet frequently enough to ensure that no new or ongoing reports go more than 60 days without being reviewed by the team.
> B. The following individuals, or their designees, shall participate in review meetings of the multidisciplinary team: the attorney for the Commonwealth; law-enforcement officials responsible for the investigation of sex offenses involving a child in the jurisdiction; a representative of the local child protective services unit; a representative of a child advocacy center serving the jurisdiction, if one exists; and a representative of an Internet Crimes Against Children task force affiliate agency serving the jurisdiction, if one exists. In addition, the attorney for the Commonwealth may invite other individuals, or their designees, including the school superintendent of the jurisdiction; a representative of any sexual assault crisis center serving the jurisdiction, if one exists; the director of the victim/witness program serving the jurisdiction, if one exists; and a health professional knowledgeable in the treatment and provision of services to children who have been sexually abused.

These meetings are considered closed and therefore the discussions in these meetings are not public information pursuant to § 2.2.3711 of the Code of Virginia. The findings of the team may be disclosed or published in statistical or other aggregated form that does not disclose the identity of specific individuals pursuant to § 2.2.3705.7 of the Code of Virginia.

1.7 Family partnership meetings

Family engagement is a relationship focused approach that provides structure for decision making that empowers both the family and the community in the decision making

process. Family partnership meetings (FPM) are grounded by value-driven principles that include:

- All families have strengths.
- Families are the experts on themselves.
- Families deserve to be treated with dignity and respect.
- Families can make well-informed decisions about keeping their children safe when supported.
- Outcomes improve when families are involved in decision making.
- A team is often more capable of creative and high quality decision making than an individual.

A FPM may be held any time to solicit family input regarding safety, services and permanency planning; however, for every family involved with the child welfare agency these are the decision points at which a FPM should be held:

- Once a CPS investigation or family assessment has been completed and the family is identified as “very high” or “high” risk and the child is at risk of out of home placement.
- Prior to removing a child, whether emergency or considered.
- Prior to any change of placement for a child already in care, including a disruption in the adoptive placement.
- Prior to the development of a foster care plan for the foster care review and permanency planning hearings to discuss permanency options and for concurrent planning as well as consideration of a change of goal.
- When requested by parent (birth, foster, adoptive or legal guardian), youth, or service worker.

The worker and supervisor should discuss the convening and timing of a family partnership meeting at these critical decision points. All family partnership meetings must be documented in the child welfare information system. For more guidance regarding

family partnership meetings, please refer to the VDSS Child and Family Services manual, Family Engagement chapter on the DSS public website .

Course CWS4030: Facilitator Training for Virginia's Family Partnership Meetings is designed for individuals within the locality that will be responsible for facilitating family partnership meetings.

1.8 Structured Decision Making

Structured Decision Making (SDM) is a process that uses a set of research and evidence-based assessment tools to help case workers make appropriate decisions at key stages in the child welfare process, from screening referrals to closing cases. When partnered with clinical judgment and supervision, these tools are designed to increase the consistency of casework decisions and improve the validity of those decisions, thereby better protecting children from harm. The assessment tools apply to all CPS decisions, with the exception of out-of-family reports, which only require the use of the Intake Tool. The assessment tools must be completed in the child welfare information system. When accessed via the child welfare information system, each assessment tool has definitions available that assist the worker with making the best choices on the tool. It is critical that workers refer to the definitions in the tools for consistency in completing the tools. Guidance on when to use each tool is offered in subsequent parts of this manual.

Additional information on the SDM tools can be located in CWSE1510: Structured Decision Making in Virginia. This on-line course is available in the VLC.

1.9 Domestic Violence

Domestic violence (DV) is an issue affecting many families receiving services through the LDSS. VDSS has added a new chapter to the VDSS Child and Family Services Manual, Chapter H. Domestic Violence. This chapter presents an overview of DV and the related statutory requirements impacting LDSS and local DV programs. Information specific to Prevention, CPS and Foster Care is provided. Much of the specific information is applicable across program areas. This chapter also connects to the existing chapters of entire VDSS Child and Family Services Manual to ensure that specific DV information is readily available when needed.

Local DV programs provide services which focus on the safety of DV victims and their children. LDSS focus primarily on child safety. Both entities are focused on safety. LDSS

and local DV programs work together, participate in multi-disciplinary teams together, occasionally are housed in the same buildings and often work with the same families.

Current data regarding the co-occurrence between DV and child maltreatment compel child welfare systems to re-evaluate existing philosophies, policies, and practice approaches towards families experiencing both forms of violence.

1.10 Sex trafficking of children

Sex trafficking is defined in the Trafficking Victims Protection Act of 2000 (22 U.S.C. 7102) as the recruitment, harboring, transportation, provision, obtaining, patronizing or soliciting of a person for the purpose of a commercial sex act. Research suggests that children currently or formerly in foster care are at a higher risk of being sex trafficked. Risk factors include but are not limited to:

- Limited or severed family connections.
- History of emotional trauma, physical or sexual abuse.
- Prior involvement with law enforcement.

The Preventing Sex Trafficking and Strengthening Families Act (P.L.113-183) requires states to identify, document and determine the appropriate services for children and youth who are victims or at risk of being sex trafficked. The information obtained in this process may assist in identifying characteristics, signs and vulnerabilities to respond to youth who have been sex trafficked and inform communities how to help combat future incidents.

The Justice for Victims of Trafficking Act of 2015 (H.R.181) amends CAPTA to include victims of sex trafficking in the definition of an abused or neglected child.

Additional information regarding sex trafficking can be found in the on-line course, CWSE4000: Identifying Sex Trafficking in Child Welfare. This course is available on the VDSS public website and in the VLC.

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1.11 Appendix A: Indian Child Welfare Act (ICWA)

The Indian Child Welfare Act (ICWA) is a federal law passed in 1978 that guides states in their process for placement of an Indian child that is in their custody. It requires that states seek placement for the child with that child's family, tribe and other American Indian homes before looking elsewhere. It generally does not apply to divorce proceedings, interfamilial disputes, juvenile delinquency cases or cases under tribal court jurisdiction.

While most of ICWA is related to children who have been removed and are in the custody of LDSS, there are specific elements of ICWA that require early identification of ICWA applicability. Early identification will promote proper implementation of ICWA at an early stage to prevent, as much as possible, delayed discoveries that ICWA applies. Early discovery of ICWA applicability will ensure that:

- Proper notice is given to parents/Indian custodians and tribes.
- Tribes have the opportunity to intervene or take jurisdiction over proceedings (as appropriate).
- ICWA placement preferences are respected.

1.11.1 Active efforts

The requirement to engage in "active efforts" begins from the moment the possibility arises that the investigation, family assessment or case may result in the need for the Indian child to be placed outside the custody of either parent or Indian custodian in order to prevent removal. The U.S. Department of the Interior, Bureau of Indian Affairs Division of Human Services, provides a quick reference sheet on active efforts.

Active efforts to prevent removal of the child must be conducted while investigating whether the child is a member of the tribe, is eligible for membership in the tribe or whether a biological parent of the child is or is not a member of a tribe.

Active efforts are intended primarily to maintain and reunite an Indian child with his/her family or tribal community and constitute more than "reasonable efforts" as required by Title IV-E of the Social Security Act.

Active efforts include, but are not limited to:

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- Engaging the Indian child, the Indian child's parents, the Indian child's extended family members and the Indian child's custodian.
- Taking necessary steps to keep siblings together.
- Identifying appropriate services and helping the parents to overcome barriers, including actively assisting (not just referring) the parents in obtaining such services.
- Identifying, notifying and inviting representatives of the Indian child's tribe to participate.
- Conducting or causing to be conducted a diligent search for the Indian child's extended family members for assistance and possible placement (if needed).
- Taking into account the Indian child's tribe's prevailing social and cultural conditions and way of life and requesting the assistance of representatives designated by the Indian child's tribe with substantial knowledge of the prevailing social and cultural standards.
- Offering and employing all available and culturally appropriate family preservation strategies.
- Identifying community resources and actively assisting the Indian child's parents or extended family in utilizing and accessing those resources.
- Monitoring progress and participation in services.

1.11.2 Indian child

Indian child means any unmarried person less than 18 years of age who is either:

- A member of an Indian tribe.
- Eligible for membership in an Indian tribe and the biological child of a member of an Indian tribe.

1.11.3 ICWA applicability

When does ICWA apply?

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- Whenever an Indian child is the subject of a child custody proceeding.
- In those cases in which the Indian child is not removed from the home, such as during an investigation, family assessment or case. This includes instances when a court orders the family to engage in services to keep the child in the home as part of a diversion, differential, alternative response or other program. LDSS and courts should follow the verification and notice provisions.

When does ICWA not apply?

- Tribal court proceedings.
- Placements based upon an act by the Indian child which if committed by an adult would be deemed a criminal offense.
- An award in a divorce proceeding of custody of the Indian child to one of the parents.
- Voluntary placements that do not operate to prohibit the child's parent or Indian custodian from regaining custody of the child upon demand.

1.11.4 Determination of tribal membership

- The LDSS and court must treat the child as an Indian child unless and until it is determined that the child is not of American Indian, Alaskan Eskimo or Aleut heritage, and the child does not belong to a tribe located in or outside of Virginia.
- Only the Indian tribe(s) of which it is believed a biological parent or the child is a member or eligible for membership may make the determination whether the child is a member of the tribe(s); is eligible for membership in the tribe(s); or whether the parent of the child is a member of the tribe(s).
- The LDSS must submit a written request to the Tribal Social Service or ICWA Representative of the prospective tribe and request confirmation of the child's membership or eligibility for membership as the biological child of a member of the tribe. The LDSS must provide all identifying information to the tribe to assist in the confirmation or determination of tribal membership. Appendix B: Tribal Resources provides information on identifying the Tribal Social Service or ICWA representative of each tribe.

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1.11.5 Documentation of Indian status

- The LDSS must document all “active efforts” in the child welfare information system.
- The LDSS must document the steps taken to determine the status of the child in the child welfare information system. *The worker must select “Indian Status” as a purpose of the Interviews & Interactions in the child welfare information system.*
- The LDSS must document any determinations that have been made regarding the status of the child in the child welfare information system.

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1.12 Appendix B: Tribal Resources

1.12.1 Virginia tribes

In Virginia, there are state and federally recognized Indian tribes. State-recognized Indian tribes are not necessarily federally recognized; however, some federally recognized tribes are also recognized by the Commonwealth of Virginia. Recognition at the state and federal levels determines the array of protections, resources, and services available to the tribes from the state and federal government.

1.12.2 Virginia tribes recognized by the Commonwealth of Virginia

State recognition of an American Indian tribe is the declaration of a formal relationship between the American Indian tribe and the Commonwealth of Virginia.

Tribe	Year Recognized	Location
Chickahominy Tribe	1983	Charles City County
Eastern Chickahominy Indian Tribe	1983	New Kent County
Mattaponi Tribe	1983	Banks of Mattaponi River, King William County
Monacan Indian Nation	1989	Bear Mountain, Amherst County
Nansemond Indian Tribal Association	1985	Cities of Suffolk and Chesapeake
Rappahannock Indian Tribe	1983	Indian Neck, King & Queen County
Upper Mattaponi Indian Tribe	1983	King William County
Cheroenhaka (Nottoway) Indian Tribe	2010	Courtland, Southampton County
Nottoway of Virginia	2010	Capron, Southampton County

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Patawomeck Indians of Virginia	2010	Stafford County

1.12.3 Virginia tribal resources

The Secretary of the Commonwealth maintains a contact list for Virginia tribes.

- LDSS are strongly encouraged to contact Virginia tribes in their service areas and work to build and strengthen relationships in order to improve services to Indian children and their families.
- The Eastern Regional Office--Bureau of Indian Affairs can provide guidance on ICWA notification procedures for children associated with state recognized tribes.

1.12.4 Federally recognized tribes in Virginia

Federal recognition of an American Indian tribe confirms the existence of a nation-to-nation relationship between the Indian tribe and the United States, and permanently establishes a government-to-government relationship between the two.

Tribe	Year Recognized	Location
Virginia Pamunkey Indian Tribe	2016	King William County
Chickahominy Tribe	2018	Charles City County
Eastern Chickahominy Indian Tribe	2018	New Kent County
Monacan Indian Nation	2018	Bear Mountain, Amherst County
Nansemond Indian Tribal Association	2018	Cities of Suffolk and Chesapeake
Rappahannock Indian Tribe	2018	Indian Neck, King & Queen County
Upper Mattaponi Indian Tribe	2018	King William County

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1.12.5 Federal tribal resources

The U.S. Department of the Interior Bureau of Indian Affairs was established to enhance the quality of life, promote economic opportunity, and carry out the responsibility to protect and improve the trust assets of American Indians, Indian tribes, and Alaska Natives. The Bureau of Indian Affairs serves as the liaison between the Federal Government and Indian tribes and Alaska Native villages in the United States.

The U.S. Department of the Interior Bureau of Indian Affairs maintains a Tribal Leaders Directory with contact information for each of the federally recognized tribes.

The U.S. Department of the Interior Bureau of Indian Affairs maintains regional offices across the United States. The regional offices provide direct support and resources to federally recognized tribes. The BIA Directory of Regional Offices provides contact information for each regional office. There are twelve regional offices. Regional offices can assist the LDSS with identification of the Child Welfare Designated Agent for each tribe. The Child Welfare Designated Agent will be able to provide contact information for the tribal social service program or ICWA representative of each tribe.

The U.S. Department of the Interior Bureau of Indian Affairs Division of Human Services oversees the administration of the Indian Child Welfare Act. They provide a number of resource guides for tribes, state agencies, and courts regarding the ICWA.

- Quick Reference Sheet for State Agency Personnel.
- Quick Reference Sheet for State Court Personnel.
- Quick Reference Sheet for Tribes.
- Sample Notice of Child Custody Proceeding for Indian Child.

The National Indian Child Welfare Association is a comprehensive source of information on American Indian child welfare. They are the only national American Indian organization focused specifically on the tribal capacity to prevent child abuse and neglect.

The Indian Health Service is an agency within the Department of Health and Human Services responsible for providing federal health services to American Indians and Alaska Natives.

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DEFINITIONS OF ABUSE AND NEGLECT

TABLE OF CONTENTS

DRAFT

DRAFT

DRAFT

DRAFT

DRAFT

2

DEFINITIONS OF ABUSE AND NEGLECT

2.1 Introduction

The statutory and regulatory authority establishing the foundation for the categories of abuse and neglect are found in Chapter 15 of the Code of Virginia and 22 VAC 40-705-30 of the Virginia Administrative Code (VAC). This section also contains footnotes of relevant court decisions impacting the definition of abuse and neglect for the CPS program.

The VAC defines abuser or neglector as:

> (22 VAC 40-705-10). "Abuser or Neglector" means any person who is found to have committed the abuse or neglect of a child pursuant to Chapter 15 (§ 63.2-1500 et seq.) of Title 63.2 of the Code of Virginia.

The VAC establishes four (4) categories of abuse or neglect, including:

- Physical abuse.
- Physical neglect (includes medical neglect).
- Mental abuse or neglect.
- Sexual abuse.

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CWSE2090: Injury Identification in Child Welfare is an e-learning course designed for all child welfare workers. This course is recommended for all CPS workers and supervisors as it will increase knowledge and ability to recognize signs of abuse and neglect. It is available in the VLC.

2.2 Injury and threat of injury or harm to a child

Inherent within each category of abuse or neglect is an actual injury or the existence of a threat of an injury or harm to the child. Although there are five categories of abuse or neglect, there are only two kinds of injuries possible; an injury may be a physical injury or a mental injury. Also, an injury may be an actual injury or a threatened injury. The threat of injury has been upheld by the courts.[1]

The CPS worker must consider the circumstances surrounding the alleged act or omission by the caretaker influencing whether the child sustained an injury or whether there was a threat of an injury or of harm to the child. The evidence may establish circumstances that may create a threat of harm.

2.3 Physical abuse

2.3.1 Statutory and regulatory definition

The Code of Virginia § 63.2 -100 provides the statutory definition of physical abuse. The Virginia Administrative Code provides the same definition of physical abuse:

> (22 VAC 40-705-30 A). Physical abuse occurs when a caretaker creates or inflicts, threatens to create or inflict, or allows to be created or inflicted upon a child a physical injury by other than accidental means or creates a substantial risk of death, disfigurement, or impairment of bodily functions, including, but not limited to, a child who is with his parent or other person responsible for his care either (i) during the manufacture or attempted manufacture of a Schedule I or II controlled substance or (ii) during the unlawful sale of such substance by that child's parents or other person responsible for his care, where

[1] "[T]he statutory definitions of an abused or neglected child do not require proof of actual harm or impairment having been experienced by the child. The term 'substantial risk' speaks in futuro." *Jenkins v. Winchester Dep't of Soc. Servs.*, 12 Va. App. 1178, 1183, 409 S.E.2d 16, 19 (1991). "The Commonwealth's policy is to protect abused children and to prevent further abuse of those children. This policy would be meaningless if the child must suffer an actual injury from the behavior of his or her parent . . . . [T]he statute [does not] impose such trauma upon a child." *Jackson v. W.*, 14 Va. App. 391, 402, 419 S.E.2d 385, 391 (1992).

> such manufacture, or attempted manufacture or unlawful sale would constitute a felony violation of § 18.2-248 of the Code of Virginia.

2.3.2 Types of physical abuse

The types of physical abuse include but are not limited to:

2.3.2.1 Asphyxiation *and strangulation*

Asphyxiation means being rendered unconscious as a result of oxygen deprivation.

Strangulation means obstruction of carotid or jugular veins that may or may not result in a loss of consciousness. Injuries may be internal and not immediately visible and may result in delayed medical complications.

2.3.2.2 Bone fracture

- Chip fracture. A small piece of bone is flaked from the major part of the bone.
- Simple fracture. The bone is broken, but there is no external wound.
- Compound fracture. The bone is broken, and there is an external wound leading down to the site of fracture or fragments of bone protrude through the skin.
- Comminuted fracture. The bone is broken or splintered into pieces.
- Spiral fracture. Twisting causes the line of the fracture to encircle the bone in the form of a spiral.

2.3.2.3 Head injuries

- Brain damage. Injury to the large, soft mass of nerve tissue contained within the cranium or skull.
- Skull fracture. A broken bone in the skull.

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- Subdural hematoma. A swelling or mass of blood (usually clotted) caused by a break in a blood vessel located beneath the outer membrane covering the spinal cord and brain.

2.3.2.4 Burns/scalding

- Burn. Tissue injury resulting from excessive exposure to thermal, chemical, electrical or radioactive agents.
- Scald. A burn to the skin or flesh caused by moist heat from vapors or steam.
- The degree of a burn must be classified by a physician and is usually classified as:
- First degree. Superficial burns, damage being limited to the outer layer of skin, scorching or painful redness of the skin.
- Second degree. The damage extends through the outer layer of the skin into the inner layers. Blistering will be present within 24 hours.
- Third degree. The skin is destroyed with damage extending into underlying tissues, which may be charred or coagulated.

2.3.2.5 Cuts, bruises, welts, abrasions

- Cut. An opening, incision, or break in the skin.
- Bruise. An injury that results in bleeding within the skin, where the skin is discolored but not broken.
- Welt. An elevation on the skin produced by a lash or blow. The skin is not broken.
- Abrasions. Areas of the skin where patches of the surface have been scraped off.

2.3.2.6 Internal injuries

An injury that is not visible from the outside, such as an injury to the organs occupying the thoracic or abdominal cavities.

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2.3.2.7 Poisoning

Ingestion, inhalation, injection, or absorption of any substance given to a child that interferes with normal physiological functions. The term poison implies an excessive amount as well as a specific group of substances. Virtually any substance can be poisonous if consumed in sufficient quantity.

Poisoning occurs when the caretaker intends to alter the child's normal physiological functions by giving the substance to the child. It does not include acts of omission where the caretaker allows access to substances that alter the child's normal physiological functions. Those situations should be evaluated based on the definition of physical neglect.

2.3.2.8 Sprains/dislocation

- Sprain. Trauma to a joint which causes pain and disability depending upon the degree of injury to ligaments. In a severe sprain, ligaments may be completely torn.
- Dislocation. The displacement of a bone from its normal position in a joint.

2.3.2.9 Gunshot wounds

Wounds resulting from a gunshot.

2.3.2.10 Stabbing wounds

Wounds resulting from a stabbing.

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2.3.2.11 Munchausen syndrome by proxy

A condition characterized by habitual presentation for hospital treatment of an apparent acute illness, the patient giving a plausible and dramatic history, all of which is false.[2] Munchausen syndrome by proxy occurs when a parent or guardian falsifies a child's medical history or alters a child's laboratory test or actually causes an illness or injury in a child in order to gain medical attention for the child, which may result in innumerable harmful hospital procedures.[3] This classification must be supported by medical evidence. *Munchausen syndrome by proxy is also referred to as Factitious Disorder Imposed on Another.*

2.3.2.12 Bizarre discipline

Bizarre discipline means any actions in which the caretaker uses eccentric, irrational, or grossly inappropriate procedures or devices to modify the child's behavior. The caretaker's actions must result in physical harm to the child or create the threat of physical harm to the child.

Bizarre discipline is also a type of mental abuse or neglect.

2.3.2.13 Abusive Head Trauma and battered child syndrome

Abusive Head Trauma (AHT), also known as traumatic inflicted brain injury or shaken baby syndrome, and battered child syndrome are caused by non-accidental trauma.

- **Abusive Head Trauma** is a medical diagnosis that must be made by a physician. This type of injury occurs during violent shaking of an infant or young child causing the child's head to whip back and forth. The shaking causes the child's brain to move about, causing blood vessels in the skull to stretch and tear. The child may suffer one or several of the following injuries: retinal hemorrhages; subdural or subarachnoid hemorrhages; cerebral contusions; skull fracture; rib fractures; fractures in the long bones and limbs; metaphyseal fractures; axonal shearing (tearing of the

[2] Dorland's Illustrated Medical Dictionary 1295 (26th ed. 1981).

[3] Zumwalt & Hirsch, Pathology of Fatal Child Abuse and Neglect, in Child Abuse and Neglect 276 (R. Helfer & R. Kempe eds., 4th ed. 1987).

brain tissue); and cerebral edema (swelling of the brain). The absence of external injury does not rule out a diagnosis of shaken baby syndrome.

In response to debate and controversy within the legal system and the media, the American Academy of Pediatrics (AAP) has published an informative resource which states there is no legitimate medical debate among the majority of practicing physicians as to the existence or validity of AHT. Claims that shaking is not dangerous to infants or children are not factual and are not supported by AAP policy, despite being proffered by a few expert witnesses in the courtroom. This resource can be used to educate judges, prosecutors, child welfare specialists and other decision makers about this important issue. The resource is available here.

- **Battered child syndrome** refers to a "constellation of medical and psychological conditions of a child who has suffered continuing injuries that could not be accidental and are therefore presumed to have been inflicted by someone close to the child, usually a caregiver. Diagnosis typically results from a radiological finding of distinct bone trauma and persistent tissue damage caused by intentional injury, such as twisting or hitting with violence."[4] The battered child syndrome "exists when a child has sustained repeated and/or serious injuries by non-accidental means."[5] Battered child syndrome must be diagnosed by a physician.

  Presenting signs and symptoms of this type of injury include: irritability, convulsions, seizures, lethargy or altered level of consciousness, coma, respiratory problems, vomiting, and death.[6]

2.3.2.14 Exposure to sale or manufacture of certain controlled substances

The sale of drugs by a caretaker in the presence of a child can pose a threat to the child's safety. Manufacturing drugs, especially in methamphetamine

[4] Black's Law Dictionary, 172 (9th ed. 2009).

[5] *Estelle v. McGuire*, 502 U.S. 62 (1991).

[6] Monteleone, Dr. James A., and Dr. Armand E. Brodeur, *Child Maltreatment: A Clinical Guide and Reference,* 14-16 (G.W. Medical Publishing 1994).

laboratories, can expose children to serious toxins. There is more information about specific toxins in Appendix C in Section 4, Family Assessment and Investigation, as well as information about Schedule 1 and Schedule 2 drugs on the Department of Justice website.

CPS reports alleging this type of physical abuse shall be reported to the Commonwealth Attorney and to local law enforcement. The CPS worker should not be the first responder to a setting where the manufacture of drugs is suspected.

There is a sample protocol for a joint response to these reports with local law enforcement and emergency personnel in Appendix C in Section 4, Family Assessment and Investigation.

2.3.2.15 Other physical abuse

Most types of physical abuse of a child can be defined in one of the above types. However, if the child has suffered a type of physical abuse that is not one of the above specified types, the CPS worker may document the type as Other Abuse and specifically describe the type of physical abuse.

2.3.3 Substantial risk of death, disfigurement, or impairment of bodily functions

The CPS worker may determine that a physical abuse definition has been met when the information collected during the family assessment or investigation establishes that the caretaker created a substantial risk of death, disfigurement, or impairment of bodily functions.

2.4 Physical neglect

2.4.1 Statutory and regulatory definition

The Code of Virginia § 63.2-100 provides the statutory foundation for the definition of physical neglect. The VAC provides the regulatory definition for physical neglect:

> (22 VAC 40-705-30 B). Physical neglect occurs when there is the failure to provide food, clothing, shelter, necessary medical treatment or supervision for a child to the extent that the child's health or safety is endangered. This also includes abandonment and situations where the parent or caretaker's own incapacitating behavior or absence prevents or severely

> limits the performing of child caring tasks pursuant to § 63.2 –100 of the Code of Virginia. This also includes a child under the age of 18 years whose parent or other person responsible for his care knowingly leaves the child alone in the same dwelling as a person, not related by blood or marriage, who has been convicted of an offense against a minor for which registration is required as a violent sexual offender pursuant to § 9.1-902.
>
> (22 VAC 40-705-30 B1). Physical neglect may include multiple occurrences or a one-time critical or severe event that results in a threat to health or safety.

2.4.2 Types of physical neglect

The types of physical neglect include but are not limited to:

2.4.2.1 Abandonment

Abandonment means conduct or actions by the caretaker implying a disregard of caretaking responsibilities. Such caretaker actions or conduct includes extreme lack of interest or commitment to the child, or leaving the child without a caretaker and without making proper arrangements for the care of the child and with no plan for the child's care, or demonstrating no interest or intent of returning to take custody of the child.

Abandonment may include situations when a caretaker disregards their caretaker duties, obligations and responsibilities by failing to make reasonable efforts to locate the child when the child has run away and/or is missing. Reasonable efforts include but are not limited to contacting local law enforcement to make a report that the child has run away and/or is missing.

The Code of Virginia §§ 18.2-371, 40.1-103, 8.01-226.5:2, and 63.2-910.1 provide immunity from liability to hospital and rescue squad staff who receive an abandoned infant and provide an affirmative defense in the criminal and civil statutes to any parent who is prosecuted as a result of leaving an infant with these personnel. Hospital and rescue squad staffs are still expected to report these instances of child abandonment and the LDSS is required to respond to these reports of child abandonment. Even though these statutes allow an affirmative defense for a parent abandoning her infant under certain conditions, this action still meets the definition of abandonment for a CPS response. If a removal is conducted under these circumstances, the conditions for removal should be documented as "safe haven" in the child welfare information system.

2.4.2.2 Inadequate supervision

The child has been left in the care of an inadequate caretaker or in a situation requiring judgment or actions greater than the child's level of maturity, physical condition, and/or mental abilities would reasonably dictate. Inadequate supervision includes minimal care or supervision by the caretaker resulting in placing the child in jeopardy of sexual or other exploitation, physical injury, or results in status offenses, criminal acts by the child, or alcohol or drug abuse.

Inadequate supervision includes when a caretaker of the child allows, encourages or engages in sex trafficking of the child.

Inadequate supervision includes acts of omission by the caretaker that allow the child access to substances that alter the child's normal physiological functions.

2.4.2.3 Inadequate clothing

Failure to provide appropriate and sufficient clothing for environmental conditions or failure to provide articles of proper fit that do not restrict physical growth and normal activity.

2.4.2.4 Inadequate shelter

Failure to provide protection from the weather and observable environmental hazards, which have the potential for injury or illness, in and around the home.

2.4.2.5 Inadequate personal hygiene

Failure to provide the appropriate facilities for personal cleanliness to the extent that illness, disease or social ostracism has occurred or may occur. In the case of a young child, the caretaker must not only provide such facilities but also make use of them for the child.

2.4.2.6 Inadequate food

Failure to provide and ensure an acceptable quality and quantity of diet to the extent that illness, disease, developmental delay, or impairment has occurred or may result.

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2.4.2.7 Malnutrition

Chronic lack of necessary or proper nutrition in the body caused by inadequate food, lack of food, or insufficient amounts of vitamins or minerals. This condition requires a medical diagnosis.

2.4.2.8 Knowingly leaving a child with a person required to register as *Tier III sexual* offender

The following three elements are required for this type of physical neglect:

- The parent has knowingly left the child alone with a person not related by blood or marriage.
- That person has been convicted of an offense against a minor.
- That person is required to register as a *Tier III* sexual offender pursuant to the Code of Virginia § 9.1-902.

Some of the offenses for which registration as a *Tier III* sexual offender include:

- Abduction with intent to defile.
- Rape.
- Forcible sodomy.
- Object sexual penetration.
- Aggravated sexual battery.
- Sexual battery where the perpetrator is 18 years of age or older and the victim is under the age of six.
- Taking indecent liberties with children.
- Taking indecent liberties with child by person in custodial or supervisory relationship.

In addition, the Code of Virginia requires registration as a *Tier III* sexual offender of persons who have committed certain offenses multiple times.

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To determine if the report should be validated for this type of physical neglect, the CPS worker must determine if the person is required to register as a *Tier III* sexual offender on the Virginia State Police Sex Offender and Crimes Against Minors Registry. This registry provides a complete list of offenses and the specific section of the Code of Virginia for which registration as a sex offender is required. Each registered offender's web profile will identify the person as either a *Tier I, Tier II, or Tier III* Sexual Offender. In this definition, the alleged abuser is the child's parent or other caretaker who has left the child with a person, not related by blood or marriage, required to register as a *Tier III* sex offender.

If the allegations do not meet this specific definition of physical neglect/leaving child with a known sex offender, the LDSS should evaluate the information to determine if the report should be validated as physical neglect/inadequate supervision by the child's parent or guardian. A child may still be at risk of abuse or neglect by a person who is required to register on the Sex Offender and Crimes Against Minors Registry, but who is not identified as a *Tier III* sex offender or who is related to the child by blood or marriage.

If in the course of responding to the physical neglect report, there is reason to suspect the child has been sexually abused, the local worker must enter a separate CPS referral into the child welfare information system for the sex abuse allegation, the alleged abuser and victim. Refer to Section 3, Complaints and Reports, for new allegations in an existing referral. Sexual abuse complaints shall be placed in the Investigation Track.

2.4.2.9 Failure to thrive

> (22 VAC 40-705-30 B 2 a). Failure to thrive occurs as a syndrome of infancy and early childhood that is characterized by growth failure, signs of severe malnutrition, and variable degrees of developmental retardation.
>
> (22 VAC 40-705-30 B 2 b). Failure to thrive can only be diagnosed by a physician and is caused by nonorganic factors.

Failure to thrive describes several conditions in infants and children. Failure to thrive can be caused by a number of medical problems. In some children, failure to thrive can be caused by extreme neglect. Failure to thrive describes the malnourished and depressed condition of infants, implying not only growth deficits, but also disorders of behavior and development. Failure to thrive is classified as organic failure to thrive or nonorganic failure to thrive. Only

nonorganic failure to thrive is considered to be a type of physical neglect or mental neglect. For a further discussion about failure to thrive, see Appendix B: Failure to Thrive Syndrome.

2.4.2.10 Labor trafficking

Labor trafficking means the recruitment, harboring, transportation, provision, or obtaining of a child for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.

2.4.2.11 Other physical neglect

Most types of physical neglect a child has suffered can be defined in one of the above types. However, if the child has suffered a type of physical neglect that is not one of the above specified types, the CPS worker may document the type as Other Physical neglect and specifically describe the type of physical neglect.

2.4.3 Family poverty and lack of resources

> (22 VAC 40-705-30 B). In situations where the neglect is the result of family poverty and there are no outside resources available to the family, the parent or caretaker shall not be determined to have neglected the child; however, the local department may provide appropriate services to the family.

The LDSS should not render a founded disposition of physical neglect when the neglect resulted from poverty and a lack of available resources. If the neglect resulted from poverty, then the LDSS may provide services in lieu of making a founded disposition. However, in situations where resources are available, a founded disposition may be warranted if, after appropriate services are offered, the caretakers still refuse to accept.

2.4.3.1 Multiple occurrences or one-time incident

> (22 VAC 40-705-30 B1). Physical neglect may include multiple occurrences or a one-time critical or severe event that results in a threat to health or safety.

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2.5 Medical neglect

2.5.1 Statutory and regulatory definition

The statutory foundation for the definition of medical neglect can be found in the Code of Virginia § 63.2-100. The regulatory definition of medical neglect is within the definition of physical neglect as follows:

> (22 VAC 40-705-30 B3). Physical neglect may include medical neglect.
> a. Medical neglect occurs when there is the failure by the caretaker to obtain and or follow through with a complete regimen of medical, mental or dental care for a condition that if untreated could result in illness or developmental delays. However a decision by parents or other persons legally responsible for the child to refuse a particular medical treatment for a child with a life-threatening condition shall not be deemed a refusal to provide necessary care if (i) such decision is made jointly by the parents or other person legally responsible for the child and the child; (ii) the child has reached 14 years of age and is sufficiently mature to have an informed opinion on the subject of his medical treatment; (iii) the parents or other person legally responsible for the child and the child have considered alternative treatment options; and (iv) the parents or other person legally responsible for the child and the child believe in good faith that such decision is in the child's best interest.
> b. Medical neglect also includes withholding of medically indicated treatment.

Parents and caretakers have a legal duty to support and maintain their children, including the provision of necessary medical care. Preventive health care, such as obtaining immunizations and well-baby check-ups, is a matter of parental choice. Failure to obtain preventive health care for children does not constitute medical neglect.

2.5.2 Types of medical neglect

Medical neglect includes the caretaker failing to obtain immediate necessary medical, mental or dental treatment or care for a child. Medical neglect also includes when the caretaker fails to provide or allow necessary emergency care in accordance with recommendations of a competent health care professional.

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2.5.2.1 Emergency medical care or treatment

Medical neglect includes a caretaker failing to obtain necessary emergency care or treatment. Cases of acute illness are usually considered emergencies. The clearest examples involve life-saving medical care or treatment for a child.

Other examples include parents refusing to allow a blood transfusion to save a child in shock, or parents refusing to admit a severely dehydrated child to the hospital. Medical neglect includes any life-threatening internal injuries and the parents or caretakers do not seek or provide medical treatment or care. Additional examples include, but are not limited to, situations where the child sustains a fracture, a severe burn, laceration, mutilation, maiming, or the ingestion of a dangerous substance and the caretaker fails or refuses to obtain care or treatment.

2.5.2.2 Necessary medical care or treatment

Medical neglect includes a caretaker failing to provide or allow necessary treatment or care for a child medically at risk with a diagnosed disabling or chronic condition, or disease. Such cases may involve children who will develop permanent disfigurement or disability if they do not receive treatment. Examples include children with congenital glaucoma or cataracts, which will eventually develop into blindness if surgery is not performed; a child born with a congenital anomaly of a major organ system.

Another example: Caretaker fails to provide or allow necessary treatment or care for a child medically diagnosed with a disease or condition. Diseases or conditions include, but are not limited to, those requiring continual monitoring, medication or therapy, and are left untreated by the parents or caretakers. Children at greatest medical risk are those under the care of a sub-specialist.

For example, a child has a serious seizure disorder and parents refuse to provide medication; parents' refusal places child in imminent danger. Another example: When a child with a treatable serious chronic disease or condition has frequent hospitalizations or significant deterioration because the parents ignore medical recommendations.

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2.5.2.3 Necessary dental care or treatment

Medical neglect includes a caretaker's failure to provide or allow necessary dental treatment or care for a child. Necessary dental care does not include preventive dental care.

2.5.2.4 Necessary mental care or treatment

Medical neglect includes a caretaker's failure to provide or allow necessary mental treatment or care for a child who may be depressed or at risk for suicide.

2.5.2.5 Other medical neglect

Most types of medical neglect a child may suffer can be defined in one of the above types. However, if the child has suffered a type of medical neglect that is not one of the above specified types, the CPS worker may document the type as Other Medical Neglect and specifically describe the type of medical neglect.

2.5.3 Factors to consider when determining if medical neglect definition met

It is the parent's responsibility to determine and obtain appropriate medical, mental and dental care for a child. What constitutes adequate medical treatment for a child must be decided on its own particular facts. The focus of the CPS response is whether the caretaker failed to provide medical treatment and whether the child was harmed or placed at risk of harm as a result of the failure. Cultural and religious child-rearing practices and beliefs that differ from general community standards should not be considered a basis for medical neglect, unless the practices present a specific danger to the physical or emotional safety of the child.

2.5.3.1 Treatment or care must be necessary

The statutory definition of medical neglect requires that the caretaker neglects or refuses to provide necessary care for the child's health. Therefore, the LDSS must establish that the caretaker's failure to follow through with a complete regimen of medical, mental, or dental care for a child was necessary for the child's health. The result of the caretaker's failure to provide necessary care could be illness or developmental delays.

The challenging issue is determining when medical care is necessary for the child's health. Obviously, life-saving medical treatment is necessary and falls within the definition. However, when parents or caretakers refuse medical care

that is important to their child's well-being but is not essential to life, the issue becomes more complicated in determining whether the medical care is necessary.

2.5.3.2 Parent refuses treatment for life-threatening condition

Pursuant to the Code of Virginia § 63.2-100, a parent's decision to refuse a particular medical treatment for a child with a life-threatening condition shall not be deemed a refusal to provide necessary care when all the following conditions are met:

- The decision is made jointly by the child and the parents or other person legally responsible for the child.
- The child has reached 14 years of age and sufficiently mature to have an informed opinion on the subject of his medical treatment.
- The child and the parents or other person legally responsible for the child have considered alternative treatment options.
- The child and the parents or other person legally responsible for the child believe in good faith that such decision is in the child's best interest.

(22 VAC 40-705-10). "Particular medical treatment" means a process or procedure that is recommended by conventional medical providers and accepted by the conventional medical community.

"Sufficiently mature" is determined on a case-by-case basis and means that a child has no impairment of his cognitive ability and is of a maturity level capable of having intelligent views on the subject of his health condition and medical care.

"Informed opinion" means that the child has been informed and understands the benefits and risks, to the extent known, of the treatment recommended by conventional medical providers for his condition and the alternative treatment being considered as well as the basis of efficacy for each, or lack thereof.

"Alternative treatment options" means treatments used to prevent or treat illnesses or promote health and well-being outside the realm of modern conventional medicine.

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> "Life-threatening condition" means a condition that if left untreated more likely than not will result in death and for which the recommended medical treatments carry a probable chance of impairing the health of the individual or a risk of terminating the life of the individual.

2.5.4 Child under alternative treatment

> (22 VAC 40-705-30 B-3b(1)). A child who, in good faith, is under treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination shall not for that reason alone be considered a neglected child in accordance with § 63.2-100 of the Code of Virginia,

The Code of Virginia provides that no child shall be considered an abused or neglected child only for the reason that the child is under treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination. The religious exemption to a founded disposition of child abuse or neglect mirrors the statute providing a religious defense to criminal child abuse and neglect.[7] This exemption means that a founded disposition cannot be based only upon the religious practices of the parents or caretakers. A founded disposition can be rendered for other reasons. For example, if the parent caused the injury in the first place, the religious exemption would not apply. The religious exemption to a founded disposition of abuse or neglect is designed to protect a family's right to freedom of religion. The religious exemption statute is not to provide a shield for a person to abuse or neglect a child.[8]

Should there be a question concerning whether a child is under the treatment in accordance with a tenet or practice of a recognized church or religious denomination, the LDSS should seek the court's assistance. The court should decide whether the

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[7] See Code of Virginia § 18.2-371.1 C. Any parent, guardian or other person having care, custody, or control of a minor child who in good faith is under treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination shall not, for that reason alone, be considered in violation of this section.

[8] The United States Supreme Court held in 1944 that "parents may be free to become martyrs themselves. But it does not follow that they are free, in identical circumstances, to make martyrs of their children before they can reach the age of full and legal discretion when they can make that choice for themselves." *Prince v. Massachusetts*, 321 U.S. 158, 170 (1944).

parent or caretaker is adhering to religious beliefs as the basis for refusal of medical or dental treatment.

2.5.5 Medical neglect of infants with life-threatening conditions

The VAC 22 VAC 40-705-30 B3b(2) states that medical neglect includes withholding of medically indicated treatment. The definition section of 22 VAC 40-705-10 et seq. defines withholding of medically indicated treatment as specific to infants. When conducting an investigation involving an infant deprived of necessary medical treatment or care, the LDSS must be aware of the ancillary definitions and guidance requirements.

> (22 VAC 40-705-10). "Withholding of medically indicated treatment" means the failure to respond to the infant's life-threatening condition by providing treatment (including appropriate nutrition, hydration, and medication) which in the treating physician's or physicians' reasonable medical judgment will be most likely to be effective in ameliorating or correcting all such conditions.

This definition applies to situations where parents do not attempt to get a diagnosis even when the child's symptoms are severe and observable.

2.5.5.1 Withholding of medically indicated treatment when treatment is futile

> (22 VAC 40-705-30 B3b(2)). For the purposes of this chapter, "withholding of medically indicated treatment" does not include the failure to provide treatment (other than appropriate nutrition, hydration, or medication) to an infant when in the treating physician's or physicians' reasonable medical judgment:
>
> (a) The infant is chronically and irreversibly comatose;
>
> (b) The infant has a terminal condition and the provision of such treatment would (i) merely prolong dying; (ii) not be effective in ameliorating or correcting all of the infant's life-threatening conditions; (iii) otherwise be futile in terms of the survival of the infant; or (iv) be virtually futile in terms of the survival of the infant and the treatment itself under such circumstances would be inhumane.

2.5.5.2 Definitions of chronically and irreversibly comatose and terminal condition

> (22 VAC 40-705-10). "Chronically and irreversibly comatose" means a condition caused by injury, disease or illness in which a patient has suffered a loss of consciousness with no behavioral evidence of self-awareness or awareness of surroundings in a learned manner other than reflexive activity of muscles and nerves for low-level conditioned response and from which to a reasonable degree of medical probability there can be no recovery.
>
> (22 VAC 40-705-10). "Terminal condition" means a condition caused by injury, disease or illness from which to a reasonable degree of medical probability a patient cannot recover and (i) the patient's death is imminent or (ii) the patient is chronically and irreversibly comatose.

2.6 Mental abuse or mental neglect

2.6.1 Statutory and regulatory authority

The Code of Virginia § 63.2-100 defines abused or neglected child. The Virginia Administrative Code defines mental abuse or neglect.

> (22 VAC 40-705-30 C). Mental abuse or neglect occurs when a caretaker creates or inflicts, threatens to create or inflict, or allows to be created or inflicted upon such child a mental injury by other than accidental means or creates a substantial risk of impairment of mental functions.

2.6.2 Caretaker's actions or omissions

> (22VAC 40-705-30 C1). Mental abuse or mental neglect includes acts or omissions by the caretaker resulting in harm to a child's psychological or emotional health or development.

As a result of the caretaker's action or inaction, the child demonstrates or may demonstrate psychological or emotional dysfunction.

Mental abuse or mental neglect may result from caretaker actions or inactions such as: overprotection, ignoring, indifference, rigidity, apathy, chaotic lifestyle, or other behaviors related to the caretaker's own mental problems.

Mental abuse or mental neglect may result from caretaker behavior, which is rejecting, chaotic, bizarre, violent, or hostile. Such behavior may include bizarre discipline.

Bizarre discipline means any actions in which the caretaker uses eccentric, irrational or grossly inappropriate procedures or devices to modify the child's behavior. The consequence for the child may be mental injury or the denial of basic physical necessities or the threat of mental injury or denial of basic physical necessities.

Mental abuse or mental neglect includes the caretaker verbally abusing the child resulting in mental dysfunction. The caretaker creates a climate of fear, bullies and frightens the child. The caretaker's actions include patterns of criticizing, intimidating, humiliating, ridiculing, shouting or excessively guilt producing. Such behavior by the caretaker may result in demonstrated dysfunction by the child or the threat of harm to the child's mental functioning.

Mental abuse or mental neglect may also include incidents of domestic violence (DV) when the DV may result in demonstrated dysfunction by the child or the threat of dysfunction in the child's mental functioning. Additional information on DV and child welfare can be located in Chapter H. of the Child and Family Services Manual.

2.6.3 Documentation required for mental abuse or mental neglect

> (22VAC40-705-30 C2). Documentation supporting a nexus between the actions or inactions of the caretaker and the mental dysfunction demonstrated by the child is required in order to make a founded disposition.

When making a founded disposition of mental abuse or mental neglect, the CPS worker shall obtain documentation supporting a nexus between the actions or inactions of the caretaker and the mental dysfunction demonstrated by the child or the threat of mental dysfunction in the child. Documentation may include psychiatric evaluations or examinations, psychological evaluations or examinations, written summaries and letters. Documentation may be authored by psychiatrists, psychologists, Licensed Professional Counselors (L.P.C.), Licensed Clinical Social Workers (L.C.S.W.), or any person acting in a professional capacity and providing therapy or services to a child or family in relationship to the alleged mental abuse. An employee of the LDSS may not serve as both the CPS investigator and the professional who documents mental abuse or mental neglect.

Failure to thrive describes several conditions in infants and children. Failure to thrive can be caused by a number of medical problems. In some children, failure to thrive can be caused by extreme neglect. Failure to thrive describes the malnourished and depressed condition of infants, implying not only growth deficits, but also disorders of behavior and development.

Failure to thrive is classified as organic failure to thrive or nonorganic failure to thrive. Only nonorganic failure to thrive is considered to be a type of physical neglect or mental neglect. For a further discussion about failure to thrive, see Appendix B: Failure to Thrive Syndrome.

2.6.4 Organic failure to thrive

Failure to thrive is used to designate growth failure both as a symptom and as a syndrome.[9] As a symptom, it occurs in early childhood with a variety of acute or chronic illnesses that are known to interfere with normal nutrient intake, absorption, metabolism, or excretion, or to result in greater-than-normal energy requirements to sustain or promote growth. In these instances, it is referred to as organic failure to thrive and is not considered to be a child abuse or neglect.

2.6.5 Nonorganic failure to thrive

> (22 VAC 40-705-30 C3). Mental Abuse or neglect may include failure to thrive.
>
> a. Failure to thrive occurs as a syndrome of infancy and early childhood that is characterized by growth failure, signs of severe malnutrition, and variable degrees of developmental retardation.
>
> b. Failure to thrive can only be diagnosed by a physician and is caused by nonorganic factors.

Nonorganic failure to thrive is considered to be physical neglect or mental abuse or neglect. Nonorganic failure to thrive most commonly refers to growth failure in the infant or child who suffers from environmental neglect or stimulus deprivation[10]. Nonorganic failure to thrive generally indicates the absence of a physiologic disorder sufficient to account for the observed growth deficiency.

Most children with nonorganic failure to thrive will manifest growth failure before one year of age, and in many children growth failure will become evident by 6 months of age. Nonorganic failure to thrive may be due to impoverishment, poor understanding of feeding techniques, improperly prepared formula, or inadequate supply of breast

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[9] Berkow, M.D., Robert, Andrew J. Fletcher, M.B., Mark H. Beers, M.D., and Anil R. Londhe, Ph.D., Internet Edition-The Merck Manual, *Section 15, Pediatrics and Genetics,*

191. Developmental Problems, (17th ed. 1992).

[10] Id.

milk. Nonorganic failure to thrive is an interactional disorder in which parental expectations, parental skills and the home environment are intertwined with the child's development.[11] If left untreated, failure to thrive can lead to restricted growth and mental development. In extreme cases, it can be fatal.

2.6.5.1 Establish nexus with caretaker's action or inaction and the nonorganic failure to thrive

When making a disposition, the CPS worker must establish a link between the caretaker's actions or inactions and the fact that the child suffers from nonorganic failure to thrive.

When responding to an allegation of failure to thrive, the LDSS should consider whether the caretaker sought accredited medical assistance and was aware of the seriousness of the child's affliction. The LDSS should consider whether the parents or caretakers provided an acceptable course of medical treatment for their child in light of all the surrounding circumstances.

2.7 Sexual abuse

2.7.1 Statutory definition

The Code of Virginia § 63.2-100 *defines an abused and neglected child*.

> *(§ 63.2-100). An abused or neglected child includes any child less than 18 years of age whose parents or other person responsible for his care, or an intimate partner of such parent or person, commits or allows to be committed any act of sexual exploitation or any sexual act upon a child in violation of the law.*

Although there is a definition of criminal sexual abuse in § 18.2-67.10 6, the CPS worker should consult with the local Commonwealth's Attorney or law enforcement *with specific questions about what constitutes criminal sexual abuse*. For a discussion about physical evidence and child sexual abuse, please see Appendix D: Sexual abuse.

[11] Monteleone, Dr. James A., and Dr. Armand E. Brodeur, *Child Maltreatment: A Clinical Guide and Reference,* 14-16 (G.W. Medical Publishing 1994).

2.7.2 Types of sexual abuse

All valid CPS sexual abuse reports shall be investigated. The types of sexual abuse include but are not limited to:

2.7.2.1 Sexual exploitation

Sexual exploitation includes but is not limited to:

- The caretaker of the child allowing, permitting or encouraging a child to engage in prostitution as defined by the Code of Virginia.
- The caretaker of the child allowing, permitting, encouraging or engaging in the obscene or pornographic photographing, filming, or depicting of a child engaging in any sexual act as defined by the Code of Virginia.

2.7.2.2 Other sexual abuse

Most types of sexual abuse a child may suffer can be defined in one of the specified types. However, if the child has suffered a type of sexual abuse that is not one of the specified types, the CPS worker may document the type as Other Sexual Abuse and specifically describe the type of sexual abuse. Other sexual abuse may include, but is not limited to:

- Indecent solicitation of a child or explicit verbal or written enticement for the purpose of sexual arousal, sexual stimulation or gratification.
- Exposing the male or female genitals, pubic area or buttocks, the female breast below the top of the nipple, or the depiction of covered or uncovered male genitals in a discernibly turgid state to a child for the purpose of sexual arousal or gratification.
- Forcing a child to watch sexual conduct.
- "Sexual conduct" includes actual or explicitly simulated acts of masturbation, sodomy, sexual intercourse, bestiality, or physical contact in an act of apparent sexual stimulation or gratification with a person's clothed or unclothed genitals, pubic area, buttocks, or breast.
- Pursuant to § 18.2-370.6 of the Code of Virginia, French kissing a child younger than 13 years of age by an adult caretaker.

DRAFT

2.7.2.3 Sexual molestation

Sexual molestation means an act committed with the intent to sexually molest, arouse, or gratify any person, including, but not limited to:

- The caretaker intentionally touches the child's intimate parts or clothing directly covering such intimate parts.
- The caretaker forces the child to touch the caretaker's, the child's or another person's intimate parts or clothing directly covering such intimate parts.
- The caretaker forces another person to touch the child's intimate parts or clothing directly covering such intimate parts. "Intimate parts" means the genitalia, anus, groin, breast, or buttocks of any person.
- The caretaker causes or assists a child under the age of 13 to touch the caretaker's, the child's own, or another person's intimate parts or material directly covering such intimate parts.

2.7.2.4 Intercourse and sodomy

Intercourse or sodomy includes acts commonly known as oral sex (cunnilingus, anilingus, and fellatio), anal penetration, vaginal intercourse, and inanimate object penetration.

2.7.2.5 Sex Trafficking

The caretaker of the child allowing, encouraging or engaging in sex trafficking of the child.

> (22VAC40-705-10). "Sex trafficking" means the recruitment, harboring, transportation, provision, obtaining, patronizing or soliciting of a person for the purpose of a commercial sex act as defined in § 18.2-357.1 of the Code of Virginia.

Severe forms of trafficking means sex trafficking in which a commercial sex act is induced by force, fraud or coercion or in which the person induced to perform such act is less than 18 years of age. According to federal law, any minor under 18 years of age engaging in commercial sex is a victim of sex trafficking, regardless of the presence of force, fraud or coercion.

DRAFT

2.7.3 Establishing sexual gratification or arousal

To make a founded disposition of sexual abuse in some cases, the LDSS may be required to establish sexual gratification or arousal. It may not be necessary to prove actual sexual gratification, including but not limited to that one of the parties achieved sexual gratification. However, it may be necessary to establish that the act committed was for the purpose of sexual gratification. The VAC does not specify which party (the perpetrator or the alleged victim child) needs to be the party intended to be sexually gratified.

In some cases there will be physical evidence of sexual gratification, including but not limited to the presence of semen. Sexual gratification or arousal may be inferred by the totality of the circumstances surrounding the alleged act.[12] Sexual gratification may be established by considering the act committed and the alleged abuser's explanation or rationale for the act.[13] The act itself may be probative of the caretaker's

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[12] For example, in McKeon V. Commonwealth, 211 Va. 24, 175 S.E.2d 282 (1970), the Virginia Supreme Court held that a man who exposed his genitals to a child 35 feet away did not violate Va. Code '18.1-214 (1950). The defendant claimed that he had a robe on, and that, although there was a breeze, he did not believe his private parts became exposed. The child alleged that the man was standing on his porch smiling with his hands on his hips and his genitals exposed. The Court said that, even accepting the child's testimony as true, the Commonwealth failed to prove lascivious intent:

[T]here is no evidence that the defendant was sexually aroused; that he made any gestures toward himself or to her, that he made any improper remarks to her; or that he asked her to do anything wrong. The fact that defendant told [the victim] to turn around and that he was smiling at the time, when she was 35 feet away from him, is not proof beyond a reasonable doubt that he knowingly and intentionally exposed himself with lascivious intent.

In McKeon V. Commonwealth, the Court looked for another evidence indicating that the alleged perpetrator intentionally exposed himself to the child and found none. If the alleged perpetrator had made any comments or actions to the child suggesting that the child look at his exposed genitals, then the court may have held differently. If the alleged perpetrator had been sexually aroused and exposed himself directly to the child, the court may have sustained the conviction. However, in Campbell v. Commonwealth 227 Va. 196, 313 SE.2d 402 (1984), the court found the evidence that the perpetrator gestured to an eight-year-old girl 87 feet away from him, pulled his pants down to his knees, then gestured again was sufficient to establish lascivious intent.

[13] For example, in Walker v. Commonwealth 12 Va. App. 438, 404 S.E.2d 394 (1991), the court found the evidence sufficient to establish criminal intent in defendant's touching the vagina of a seven-year-old daughter of his girlfriend even though he claimed to be touching her to determine if she and some boys in the neighborhood had

intent to arouse or sexually gratify.[14] It may be helpful to consider the definition of lascivious intent or intent to defile, since establishing lascivious intent or intent to defile is necessary in many child sexual abuse criminal offenses.[15] When attempting to show that an act committed was for the purpose of sexual gratification, the LDSS must consider the evidence in its totality.

DRAFT

been touching each other. The court found the alleged perpetrator's explanation for touching the child's vaginal area to be woefully unsatisfactory.

[14] In some investigations, evidence establishing the act will be sufficient, in and of itself, to establish sexual gratification or arousal. For example, in Moore v. Commonwealth, 222 Va. 72, 77, 278 S.E.2d 822, 825 (1981), the court found the evidence establishing that the perpetrator touched his penis to the child's buttocks was sufficient to show defendant's lascivious intent.

[15] Lascivious is defined as "tending to excite; lust; lewd; indecent; obscene." Black's Law Dictionary 897, (8th ed. 2004). Defile is defined as "4. To morally corrupt (someone). 5. *Archaic*. To debauch (a person); to deprive (a person) of chastity." Black's Law Dictionary 455 (8th ed. 2004)

2.8 Appendix A: Battered Child Syndrome

Battered Child Syndrome refers to "a constellation of medical and psychological conditions of a child who has suffered continuing injuries that could not be accidental and are therefore presumed to have been inflicted by someone close to the child, usually a caregiver. Diagnosis typically results from a radiological finding of distinct bone trauma and persistent tissue damage caused by intentional injury, such as twisting or hitting with violence."[16] The battered child syndrome "exists when a child has sustained repeated and/or serious injuries by non-accidental means."[17]

Obvious physical signs are cuts, bruises, broken bones, or burns. Although all of these injuries can easily be caused by accidents, examinations of battered children usually find that the injuries are not compatible with the account of the accident. The exam may reveal evidence of past injuries as well. Often, the perpetrator is careful to avoid areas of the child's body that are open to view, such as the head and arms. Subsequently, teachers, friends, and others who come into contact with the child may never suspect there is a problem unless they are aware of specific behaviors commonly exhibited by battered children. Watch for surreptitious or manipulative behavior, limited impulse control, angry outbursts, and poor judgment as to what is safe or unsafe. The child may become withdrawn, use drugs or alcohol, do poorly in school, and seem to have no focus or purpose.[18]

DRAFT

[16] Black's Law Dictionary, 172 (9th ed. 2009).

[17] *Estelle v. McGuire*, 502 U.S. 62 (1991).

[18] UCSO Healthcare, *Health Guide* "Battered Child Syndrome."

2.9 Appendix B: Failure to thrive syndrome

2.9.1 Organic and nonorganic failure to thrive

Failure to thrive syndrome describes the malnourished and depressed condition of infants, implying not only growth deficits, but also disorders of behavior and development.

2.9.1.1 Organic failure to thrive

Failure to thrive is used to designate growth failure both as a symptom and as a syndrome. As a symptom, it occurs in patients with a variety of acute or chronic illnesses that are known to interfere with normal nutrient intake, absorption, metabolism, or excretion, or to result in greater-than-normal energy requirements to sustain or promote growth. In these instances, it is referred to as organic FTT.

2.9.1.2 Nonorganic failure to thrive

Nonorganic failure to thrive is an interactional disorder in which parental expectations, parental skills, and the resulting home environment are intertwined with the child's developmental capabilities. Since the mother is the primary caretaker in most families, this syndrome has been associated with maternal deprivation (see physical neglect-failure to thrive definition) and/or emotional abuse. It is characterized by physical and developmental retardation associated with a dysfunctional mother – infant relationship. Nonorganic failure to thrive involves the parents' failure to provide nurturance and attachment to the child.

When the term is used to designate a syndrome, it most commonly refers to growth failure in the infant or child who suffers from environmental neglect or stimulus deprivation. It is then designated nonorganic failure to thrive, indicating the absence of a physiological disorder sufficient to account for the observed growth deficiency.

2.9.1.3 Mixed etiology

Using the most restrictive definition, only those children who were full-term and normally grown at birth and who, by careful investigation, have no congenital or acquired illness are included in the group designated Nonorganic failure to thrive. Organic failure to thrive and nonorganic failure to thrive are not mutually exclusive. There can be children who have growth failure of mixed etiology. This

DRAFT

mixed etiology group includes children who were born prematurely but have evidence of disproportionate growth failure in later infancy; children who have or have had some defect that cannot sufficiently explain the current growth failure (e.g., successful cleft palate repair in the past); and children who are frustrating (e.g., because of a neurologically impaired suck) or extremely aversive (e.g., because of a deformity) to the care giver.

2.9.1.4 Inadequate causes

In failure to thrive of any etiology, the physiological basis for impaired growth is inadequate nutrition to support weight gain. In nonorganic failure to thrive, lack of food may be due to impoverishment, poor understanding of feeding techniques, improperly prepared formula, or inadequate supply of breast milk.

The psychological basis for nonorganic failure to thrive appears to be similar to that seen in hospitals, a syndrome observed in infants kept in sterile environments who suffer from depression secondary to stimulus deprivation. The non-stimulated child becomes depressed, apathetic, and ultimately anorexic. The unavailability of the stimulating person (usually, the mother) may be secondary to that person's own depression, poor parenting skills, anxiety in or lack of fulfillment from the caretaking role, sense of hostility toward the child, or response to real or perceived external stresses (demands of other children, marital dysfunction, a significant loss, or financial difficulties).

Nonorganic failure to thrive may be considered the result of a disordered interaction between mother and child in which the child's temperament, capacities, and responses help shape maternal nurturance patterns. Failure to thrive is not necessarily the effect of poor care giving by an inadequate or troubled mother. Nonorganic failure to thrive can be the result of a variety of interactional disorders ranging from the severely disturbed or ill child, whose care poses a major challenge to even the most competent parent, to the potentially most undemanding and compliant child being cared for by a mentally ill parent without adequate social, emotional, financial, cognitive, or physical resources. Within these extremes are maternal-child "misfits" in which the demands of the child, although not pathologic, cannot be adequately met by the mother, who might, however, do well with a child of different needs or even with the same child but under different life circumstances.

DRAFT

2.9.2 Characteristics of failure to thrive

2.9.2.1 Appearance

- Short stature (height and weight consistently fall *below* the third percentile on the Standard Growth Chart.
- Unusually thin.
- Infantile proportions.
- Potbelly (with episodes of diarrhea).
- Skin dull, pale, and cold.
- Limbs pink or purple, cold and mottled.
- Edema of the feet, legs, hands, and forearms.
- Poor skin care, excoriations, abrasions, and ulcers.
- Sparse, dry hair with patches of alopecia (hair loss).
- Dejection (avoid personal contact) and apathy (avoid eye contact).
- May have bruises, small cuts, burns, or scars (appear to be insensitive to pain and have self-inflicted injuries).

2.9.2.2 Behavior

- Passive with or without catatonia.
- Rocking or head banging.
- Retarded speech and language.
- Delayed development.
- Solitary and unable to play.
- Insomnia and disrupted sleep.

DRAFT

- Easily bullied.
- Gorging food and scavenging from garbage cans, wastebaskets, toilet bowl, or dog/cat dish.

Note: During their convalescent stay in a hospital, they have marked growth spurts that relapse as soon as they return to their home environment.

2.9.2.3 Progress in the hospital

- Rapid recover of growth and liveliness.
- Slower progress with speech and language.
- Affection seeking, but may be casual or indiscriminate.
- Attention seeking.
- Severe tantrums at the slightest frustration.
- Rocking and head banging when upset.
- Continues to want to eat and drink more than can reasonably consume and may scavenge food.

2.9.2.4 Long-term behaviors

- Speech and language immaturity.
- Gorging of food that may last six months or more.
- Restlessness with short attention span.
- Rocking and head banging if stressed.
- Difficulties with peer group and learning in school.
- Soiling and wetting (encopresis and enuresis).
- Stealing and lying.

DRAFT

- Tantrums and aggression.

2.9.2.5 Investigating allegation involving suspected failure to thrive syndrome

Nonorganic failure to thrive requires a medical diagnosis. Organic failure to thrive has to be ruled out. During the investigation, the worker should gather as much information as possible about the child and pass it on to the examining physician.

2.9.2.5.1 Basis of medical diagnosis

Engaging the parents in the search for the basis of the problem and its treatment is essential and helps to foster their self-esteem. This avoids blaming those who may already feel frustrated or guilty because of an inability to perform the most basic of parental roles—adequate nurturance of their child. The family should be encouraged to visit as often and as long as possible. They should be made to feel welcome and the staff should support their attempts to feed the child, provide toys as well as ideas that promote parent-child play and other interactions, and avoid any comments that state or imply parental inadequacy, irresponsibility, or other fault as the cause of the failure to thrive.

2.9.2.5.2 Child's growth history

The growth chart, including measurements obtained at birth if possible, should be examined to determine the child's trend in growth rate. Except in severe cases where malnutrition is obvious, the diagnosis of FTT should not be based on a single measurement, because of the wide variations existing in the normal population.

2.9.2.5.3 The child's dietary history

A detailed dietary history is essential, including techniques for preparation and feeding of formula or adequacy of breast milk supply, and feeding schedule. Observation of the primary care givers feeding the infant to evaluate their technique as well as the child's vigor of sucking should be undertaken as soon as possible. Fatigue after consumption may indicate underlying exercise intolerance; enthusiastic burping or rapid rocking during feeding may result in excessive spitting up or even vomiting; disinterest on the part of the care giver may be a sign of depression or apathy, indicating a

psychosocial environment for the infant that is devoid of stimulation and interaction.

An assessment of the child's elimination pattern to determine abnormal losses through urine, stool, or emesis should be undertaken to investigate underlying renal disease, a malabsorption syndrome, pyloric stenosis, or gastro esophageal reflux.

2.9.2.5.4 Past medical history

Past medical history inquiries should be directed toward evidence of delayed intrauterine growth or prematurity with uncompensated growth delay; of unusual, prolonged, or chronic infection; of neurologic, cardiac, pulmonary, or renal disease; or of possible food intolerance.

2.9.2.5.5 Family history

The family history should include information about familial growth patterns, especially in parents and siblings; the occurrence of diseases known to affect growth (e.g., cystic fibrosis); or recent physical or psychiatric illness that has resulted in the infant's primary care giver being unavailable or unable to provide consistent stimulation and nurturance.

2.9.2.5.6 Social history

The social history should include attention to family composition; socioeconomic status; desire for this pregnancy and acceptance of the child; parental depression; and any stresses such as job changes, family moves, separation, divorce, deaths, or other losses. Infants in large or chaotic families or infants who are unwanted may be relatively neglected because of the demands of other children, life events, or parental apathy; financial difficulties may result in over dilution of formula to "stretch" the meager supply; breast-feeding mothers who are under stress or are poorly nourished themselves may have decreased milk production.

2.9.2.5.7 Physical examination

Physical examination should include careful observation of the child's interaction with individuals in the environment and evidence of self-stimulatory behaviors (rocking, head banging). Children with Nonorganic FTT have been described as hyper vigilant and wary of close contact with people,

preferring interactions with inanimate objects if they are interactive at all. Although Nonorganic FTT is more consistent with neglectful than abusive parenting, the child should be examined carefully for any evidence of abuse. A screening test of developmental level should be performed and followed up with a more sophisticated development assessment if indicated.

2.9.3 Bibliography

The Merck Manual. Pediatrics and Genetics, Section 15. (16th ed. 1992). The Seventeenth Edition of the Merck Manual will be available in early 1998).

Bennett, S. Failure to Thrive, Pediatric Child Health 1(3):206-210, 1996.

Monteleone, J., & Brodeur, A. Child Maltreatment: A Clinical Guide and Reference, 159 (G.W. Medical Publishing 1994).

DRAFT

2.10 Appendix C: Munchausen syndrome by proxy

Munchausen syndrome by proxy in adults is "a condition characterized by habitual presentation for hospital treatment of an apparent acute illness, the patient giving a plausible and dramatic history, all of which is false."[19] "Munchausen syndrome by proxy occurs when a parent or guardian falsifies a child's medical history or alters a child's laboratory test or actually causes an illness or injury in a child in order to gain medical attention for the child which may result in innumerable harmful hospital procedures."[20] Munchausen syndrome by proxy involves an apparent deeply caring caretaker who repeatedly fabricates symptoms or provokes actual illnesses in her helpless infant or child.

Maybe the most important aspect of this syndrome is the immense ability of the caretaker to fool doctors and the susceptibility of physicians to that person's manipulations. The hospital, which is the most common setting for Munchausen syndrome by proxy cases, is where as much as 75% of the Munchausen syndrome by proxy related morbidity occurs as a consequence of attempts by physicians to diagnose and treat the affected child or infant. More than 98% of Munchausen syndrome by proxy cases involve female perpetrators.

2.10.1 Commonly fabricated illnesses and symptoms

The most common fabrications or modes of symptom inducement in Munchhausen syndrome by proxy involve seizures, failure to thrive, vomiting and diarrhea, asthma, and allergies and infections.

2.10.2 Indicators for suspecting and identifying Munchausen syndrome by proxy

- A child who has one or more medical problems that do not respond to treatment or that follow an unusual course that is persistent, puzzling, and unexplained.

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19 Dorland's Illustrated Medical Dictionary 1295 (26th ed. 1981).

20 Zumwalt & Hirsh, *Pathology of Fatal Child Abuse and Neglect*, Child Abuse and Neglect 276 (R. Helfer & Kempe eds., 4th ed. 1987).

- Physical or laboratory findings that are highly unusual, discrepant with history, or physically or clinically impossible.

- A parent, usually the mother, who appears to be medically knowledgeable and/or fascinated with medical details and hospital gossip, appears to enjoy the hospital environment, and expresses interest in the details of other patients' problems.

- A highly attentive parent who is reluctant to leave her child's side and who herself seems to require constant attention.

- A parent who appears to be unusually calm in the face of serious difficulties in her child's medical course while being highly supportive and encouraging of the physician, or one who is angry, devalues staff, and demands further intervention, more procedures, second opinions, and transfers to other more sophisticated facilities.

- The suspected parent may work in the health care field herself or profess interest in a health-related job.

- The signs and symptoms of a child's illness do not occur in the parent's absence (hospitalization and careful monitoring may be necessary to establish this causal relationship).

- A family history of similar sibling illness or unexplained sibling illness or death.

- A parent with symptoms similar to her child's own medical problems or an illness history that itself is puzzling and unusual.

- A suspected parent with an emotionally distant relationship with her spouse; the spouse often fails to visit the patient and has little contact with physicians even when the child is hospitalized with serious illness.

- A parent who reports dramatic, negative events, such as house fires, burglaries, car accidents, that affect her and her family while her child is undergoing treatment.

DRAFT

- A parent who seems to have an insatiable need for adulation or who makes self-serving efforts at public acknowledgment of her abilities.

2.10.3 Bibliography

Monteleone, J., & Brodeur, A. Child Maltreatment: A Clinical Guide and Reference, 159 (G.W. Medical Publishing 1994).

Zumwalt & Hirsh, Pathology of Fatal Child Abuse and Neglect, Child Abuse and Neglect 276 (R. Helfer & R. Kempe eds., 4th ed. 1987).

The Merck Manual. Pediatrics and Genetics, Section 15. (16th ed. 1992).

DRAFT

2.11 Appendix D: Sexual Abuse

The information below is compiled from articles and medical journals listed in the bibliography. The information is not intended to be comprehensive. If further information or clarification is needed consult a physician or the sources listed in the bibliography.

2.11.1 Physical examinations for possible sexual abuse

A normal physical examination is common in child sexual abuse. An absence of physical findings in sexually abused children can be explained in a number of ways. Many types of sexual molestation do not involve penetration and will not leave physical findings. Evidence of ejaculate may not be present if the child has washed, urinated, or defecated and if more than 72 hours has elapsed since the assault. The hymen is elastic and penetration by a finger or penis, especially in an older child, may cause no injury or may only enlarge the hymenal opening. Moreover, injuries can heal rapidly. Hymenal healing occurs in 6 to 30 days and can be complete. Partial hymenal tears can heal as soon as 9 days after injury, while extensive tears may take up to 24 days to heal.

2.11.1.1 Medical categorization of the physical examination for sexual abuse

Medical professionals commonly will classify the findings of the physical examination into one of four categories:

- Category I: Normal Appearing Genitalia. The majority (60% or more) of abused children fall into this category.
- Category II: Nonspecific Findings. Abnormalities of the genitalia that could have been caused by sexual abuse but are also seen in girls who are not victims of sexual abuse. Included in this category are redness or inflammation of the external genitalia, increased vascular pattern of the vestibular and labia mucosa, presence of purulent discharge from the vagina, small skin fissures or lacerations in the area of the posterior fourchette, and agglutination of the labia minora. Nonspecific Findings are often seen in children who have not been sexually abused.
- Category III: Specific Findings. The presence of one or more abnormalities strongly suggesting sexual abuse. Such findings include recent or healed lacerations of the hymen and vaginal mucosa, hymenal opening of one or

more centimeters, proctoepisiotomy (a laceration of the vaginal mucosa extending to involve the rectal mucosa) and indentations on the vulvar skin indicating teeth marks (bite marks). This category also includes patients with laboratory confirmation of a venereal disease (e.g., gonorrhea). Category III is suspicious or highly suspicious for sexual abuse.

- Category IV: Definitive Findings. Any presence of sperm or sexually transmitted disease. Category IV is conclusive of sexual abuse, especially with children under 12 years of age. Older children may be sexually active.

2.11.1.2 Classification of physical findings in sexual abuse examinations

Specific physical findings are strongly indicative of sexual abuse beyond reasonable doubt as follows:

- Clear-cut tears, fresh or old scars; significant distortion of the normal shape of the hymen and/or hymenal bruising.

- Lacerations, scars, bruises, and healing abraded areas, often accompanied by *neovascularization*, of the posterior fourchette.

- Anal dilation greater than 15 mm transverse diameter with gentle buttock traction with the child in knee-chest position. Large anal scars in the absence of a history that could explain the scars.

2.11.1.3 Possible physical indicators in sexually abused girls

Certain types and locations of hymenal injuries are often seen after sexual abuse. The hymenal membrane at its midline (6 o'clock position) attachment along the posterior rim of the introitus, during actual or attempted penetration, is the portion of the hymen most likely to be damaged. A narrowed (attenuated) hymen at this position is usually indicative of an injury. Mounds, projections, or notches on the edge of the hymen and the exposure of intravaginal ridges increase the possibility of abuse. Generally, attempted forced vaginal penetration results in hymenal tears and fissures between the 3 and 9 o'clock positions and may extend across the vestibule and fourchette. Other physical signs indicating abuse include:

2.11.1.4 Erythema, inflammation, and increased vascularity

In sexual abuse cases, redness of the skin or mucous membranes due to congestion of the capillaries. Normal vaginal mucosa has a pale pink coloration.

2.11.1.5 Increased friability

A small dehiscence (or breakdown) of the tissues of the posterior fourchette may be precipitated by the examination, with occasional oozing of blood. This is usually associated with labial adhesions. When the adherent area is large, greater than 2 mm, the suspicion of abuse should be greater.

2.11.1.6 Angulation of the hymenal edge

There may be V-shaped or angular configuration of the edge of the hymen. The hymenal edge should be smooth and round. Angulation often marks a healed old injury.

2.11.1.7 Labial adhesions

Although labial adhesions are a nonspecific finding often seen in girls with no history of sexual abuse, they may also be a manifestation of chronic irritation and can be seen in children who have been abused.

2.11.1.8 Urethral dilation

Urethral dilation may be an abnormal physical finding in sexually abused girls. Mild to moderate urethral dilation is probably normal, although higher grades may be considered a manifestation of sexual abuse, probably the result of digital manipulation of the urethral orifice.

2.11.1.9 Hymenal or vaginal tear

Deep breaks in the mucosa of the vagina and hymen are referred to as tears. These injuries can be seen with accidental injuries as well as with abuse. Often they occur when a history of impaling is given.

Genital injuries should be considered abuse until proven otherwise. The bony pelvis and labia usually protects the hymen from accidental injury. Straddle injuries from falls onto a pointed object, the object rarely penetrates through the hymenal orifice into the vagina. A violent stretching injury, as seen when a child

DRAFT

does a sudden, forceful split on a slippery surface, can cause midline lacerations. These injuries can also be caused during sexual abuse by forceful, sudden abduction of the legs.

2.11.1.10 Discharge

Vaginal secretions are of various consistencies, colors and odors. The usual cause of vaginal discharge in a nonspecific vaginitis. Nonspecific vaginitis is seen most often in children between two and seven years of age. Some genital discharges are not caused by infection or inflammation. The signs of nonspecific vaginitis are vaginal inflammation and discharge. The child may or may not have symptoms. The only complaint may be a yellowish stain on the child's underpants noticed by the mother. The character of the discharge, the appearance of the vaginal mucosa, and the child's symptoms do not help to identify the etiologic agent or the type of bacterial causing the infection.

2.11.1.11 Fissures

Superficial breaks in the skin or mucous membranes fissures may ooze blood and be painful. They heal completely and leave no sequelae unless they become infected in which case they may result in a small scar or an anal tag.

2.11.1.12 New or healed lacerations

Lacerations are deep breaks in the skin or mucous membranes of the vagina or anus. They often leave scar formation after healing.

2.11.1.13 Enlarged hymenal introital opening

One criterion often used to make a diagnosis of sexual abuse is an enlargement of hymenal introital opening. A vaginal introital diameter of greater than four (4) mm is highly associated with sexual contact in children less than 13 years of age. The size of the hymenal opening can vary with increasing age and pubertal development of the child. Other factors such as the position of the child during the measurement, the degree of traction placed on the external genitalia, and the degree of relaxation of the child can influence the measurements. The nature of the abuse and the time elapsed since the abuse can also change genital findings.

2.11.1.14 Sexually transmitted diseases

Transmission of sexually transmitted diseases outside the perinatal period by nonsexual means is rare. Gonorrhea or syphilis infections are diagnostic of sexual abuse after perinatal transmission has been ruled out. Herpes type 2, Chlamydia, Trichomoniasis, and condyloma infections are extremely unlikely to be due to anything but abuse, particularly in children beyond infancy.

2.11.1.15 Sperm

If the abuse occurred within 72 hours, the physical examination may reveal the presence of sperm. The survival time of sperm is shortened in prepubertal girls because they lack cervical mucus; if there is a delay before an examination, the likelihood of finding sperm is diminished.

2.11.1.16 Physical findings associated with anal sexual abuse

Anal assaults comprise a significant proportion of child sexual abuse attacks. Genital injuries or abnormalities are more often recognized as possible signs of abuse, while anal and perianal injuries may be dismissed as being associated with common bowel disorders such as constipation or diarrhea. The anal sphincter is pliant and, with care and lubrication, can easily allow passage of a penis or an object of comparable diameter without injury. The anal sphincter and anal canal are elastic and allow for dilation. Digital penetration usually does not leave a tear of the anal mucosa or sphincter. Penetration by a larger object may result in injury varying from a little swelling of the anal verge to gross tearing of the sphincter. If lubrication is used and the sphincter is relaxed, it is possible that no physical evidence will be found. Even penetration by an adult penis can occur without significant injury. After penetration, sphincter laxity, swelling, and small mucosal tears of the anal verge may be observed as well as sphincter spasm. Within a few days the swelling subsides and the mucosal tears heal. Skin tags can form as a result of the tears. Repeated anal penetration over a long period may cause a loose anal sphincter and an enlarged opening. Physical indicators of anal sexual abuse include, but are not limited to:

2.11.1.17 Perineal erythema

Reddening of the skin overlying the perineum as well as the inner aspects of the thighs and labia generally indicates that there has been intra crural intercourse (penis between legs and laid along the perineum). Erythema in this area,

however, also results from diaper rash, poor hygiene, or after scratching and irritation from pinworms.

2.11.1.18 Swelling of the perianal tissues

Circumferential perianal swelling appears as a thickened ring around the anus and has been called the tire sign. It is an acute sign and can reflect traumatic edema.

2.11.1.19 Fissures

Breaks in the skin/mucosal covering of the rectum, anus, anal skin occur as a result of overstretching and frictional force exerted on the tissues. This can occur following passage of a hard stool or abusive traumatic penetration of the anus. Tiny superficial cracks in the verge or perianal skin often result from scratching with pinworms or with excoriation from acute diarrhea or diaper rash.

2.11.1.20 Large tears

Large breaks in the skin extending into the anal canal or across the perineum are usually painful and can cause anal spasm. Tears often heal with scarring and leave a skin tag at the site of the trauma.

2.11.1.21 Skin changes

Repeated acts of penetration will lead to changes in the anal verge skin. Repeated friction and stretching of the fibers of the corrugated cutis and muscle results in thickening and smoothing away of the anal skin folds. The skin appears smooth, pink, and shiny, with a loss of normal fold pattern. The presence of these skin changes suggests chronicity of abuse. Scars are evidence of earlier trauma.

2.11.1.22 Funneling

Funneling is a traditional sign of chronic anal sexual abuse but its presence in children has been questioned. The appearance of funneling or a hollowing-out of the perianal area is caused by loss of fat tissue or fat atrophy of the subcutaneous area. Although this is often associated with chronic anal sex, it has also been described to occur in non-abused children.

DRAFT

2.11.1.23 Hematoma and/or bruising

Subcutaneous accumulations of old and new blood and bruising are strong indicators of trauma. It would be very unlikely for these to occur without a history to explain them. These injuries are not likely to be accidental.

2.11.1.24 Anal warts

Anal warts can occur as an isolated physical finding or in conjunction with other signs consistent with abuse, either anal or genital. Anal warts in children under age two years whose mother has a history of genital warts are most likely not the result of abuse. If no history of genital warts is elicited, the family should be evaluated for their presence. In children over four years of age with new genital warts, abuse should be considered and the child carefully interviewed by an experienced evaluator. Evaluation of genital warts is difficult in the nonverbal child.

2.11.1.25 Physical findings and abnormalities mistaken for anal sexual abuse

Perianal abnormalities are often seen in children with Crohn disease or Hirschsprung disease. The anal canal gapes in children with significant constipation. The distended rectum, with a normal anorectal reflex, initiates the gaping. Stool is often seen in the anal canal. Small fissures can also be seen. These children may have trouble with fecal soiling, which causes reddening of the perianal area. Unfortunately, children who were anally abused often suffer from functional constipation, which results in a damaged anal sphincter and fecal soiling. The pain and injury that follow the anal assault may cause spasm of the sphincter and result in functional constipation.

2.11.1.26 Conditions that can be mistaken for sexual abuse

- Lichen *sclerosus* et atrophicus
- Accidental straddle injuries
- Accidental impaling injuries
- Nonspecific vulvovaginitis and proctitis
- Group A streptococcal vaginitis and proctitis

DRAFT

- Diaper dermatitis
- Foreign bodies
- Lower extremity girdle paralysis as in myelomeningocele
- Defects which cause chronic constipation, *Hirschsprung* disease, anteriorly displaced anus
- Chronic gastrointestinal disease, Crohn disease
- Labial adhesions
- Anal fissures

Some dermatologic, congenital, traumatic, and infectious physical findings can be mistaken for sexual abuse. The most common dermatologic condition confused with trauma from sexual assault is lichen sclerosis. It can present in a variety of ways from mild irritation of the labia and vaginal mucosa to dramatic findings such as subepidermal hemorrhages of the genital or anal area involving the labia and vaginal mucosa and/or the anus. Monteleone, J., & Brodeur, A. Child Maltreatment: A Clinical Guide and Reference, 159 (G.W. Medical Publishing 1994).

2.11.2 Common questions and issues

These questions and answers are taken from Monteleone, J., & Brodeur, A. Child Maltreatment: A Clinical Guide and Reference, 159 (G.W. Medical Publishing 1994).

Can a child be born without a hymen to explain physical findings described?

There is no documented case of an infant girl born without a hymen.

Can excessive masturbation or the use of tampons explain abnormal vaginal findings?

Masturbation and tampons do not cause injury to the hymen or internal genital structures. There is no evidence that use of tampons causes trauma to the hymen. Masturbation in girls usually involves clitoral or labial stimulation and does not cause hymenal injury. Children who masturbate excessively or insert foreign objects into body orifices usually show no genital or anal injuries.

Can a child contract a sexually transmitted disease by merely sharing the same bed, toilet seat or towel with an infected individual?

In general, as the title implies, sexually transmitted diseases are sexually transmitted.

Can horseback riding, gymnastics or dancing cause permanent genital changes?

Injuries can occur with physical activities. When such injuries involve the genitalia, the event is very dramatic and will be reported immediately. If a physician finds hymenal changes after a child has disclosed sexual abuse or during a routine examination, injury from one of these activities is not being investigated because it would not be a reasonable explanation for the changes.

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COMPLAINTS AND REPORTS

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TABLE OF CONTENTS

DRAFT

DRAFT

DRAFT

3

COMPLAINTS AND REPORTS

3.1 Legal basis

The Code of Virginia § 63.2-1503 B and C mandates that local departments of social services (LDSS) maintain the capability to receive reports and complaints alleging abuse or neglect on a 24-hour, 7-days-a-week basis.

3.2 24-Hour hotline and receiving complaints and reports

The Virginia Administrative Code (VAC) provides that a person may make a report or complaint by telephoning the toll-free Child Abuse and Neglect Hotline of the Virginia Department of Social Services (VDSS) or by contacting a LDSS.

> (22 VAC 40-705-40 H). To make a complaint or report of child abuse or neglect, a person may telephone the department's toll-free child abuse and neglect hotline or contact a local department of jurisdiction pursuant to § 63.2-1510 of the Code of Virginia.

The statewide toll-free CPS Hotline (**1-800-552-7096**) shall be available 24 hours a day, seven days a week. After receiving a complaint or report of child abuse or neglect, the CPS State Hotline worker will refer the complaint or report to the LDSS immediately or no later than the next working day.

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3.3 Persons who may make a complaint or report

The Code of Virginia §§ 63.2-1509 and 63.2-1510 provide the authority for persons to report suspected abuse or neglect and allows any person who suspects that a child is abused or neglected to make a complaint or report. The Code of Virginia § 63.2-1509 further identifies certain persons who are mandated to report suspected abuse or neglect. The VAC defines the terms “complaint” and “report.”

> (22 VAC 40-705-10). "Complaint" means any information or allegation of child abuse or neglect made orally or in writing pursuant to § 63.2-100 of the Code of Virginia.
>
> (22 VAC 40-705-10). "Report" means either a complaint as defined in this section or an official document on which information is given concerning abuse or neglect. Pursuant to § 63.2-1509 of the Code of Virginia, a report is required to be made by persons designated herein and by local departments in those situations in which a complaint from the general public reveals suspected child abuse or neglect pursuant to the definition of abused or neglected child in § 63.2-100 of the Code of Virginia.

3.3.1 Mandated reporters

The VAC defines mandated reporters and their reporting responsibilities:

> (22 VAC 40-705-10). "Mandated reporters" means those persons who are required to report suspicions of child abuse or neglect pursuant to § 63.2-1509 of the Code of Virginia.
>
> (22 VAC 40-705-40 A). Persons who are mandated to report are those individuals defined in § 63.2-1509 of the Code of Virginia.
>
> 1. Mandated reporters shall report immediately any suspected abuse or neglect that they learn of in their professional or official capacity unless the person has actual knowledge that the same matter has already been reported to the local department or the department's toll-free child abuse and neglect hotline.
>
> 2. Pursuant to § 63.2-1509 of the Code of Virginia, if information is received by a teacher, staff member, resident, intern, or nurse in the course of his professional services in a hospital, school, or other similar institution, such person may make reports of suspected

DRAFT

abuse or neglect immediately to the person in charge of the institution or department, or his designee, who shall then make such report forthwith. If the initial report of suspected abuse or neglect is made to the person in charge of the institution or department, or his designee, such person shall (i) notify the teacher, staff member, resident, intern, or nurse who made the initial report when the report of suspected child abuse or neglect is made to the local department or to the department's toll-free child abuse and neglect hotline; (ii) provide the name of the individual receiving the report; and (iii) forward any communication resulting from the report, including any information about any actions taken regarding the report, to the person who made the initial report.

3. Mandated reporters shall disclose all information which is the basis for the suspicion of child abuse or neglect and shall make available, upon request, to the local department any records and reports which document the basis for the complaint or report.

4. Pursuant to § 63.2-1509 D of the Code of Virginia, a mandated reporter's failure to report as soon as possible, but no longer than 24 hours after having reason to suspect a reportable offense of child abuse or neglect, shall result in a fine.

5. In cases evidencing acts of rape, sodomy, or object sexual penetration as defined in Article 7 (§ 18.2-61 et seq.) of Chapter 4 of Title 18.2 of the Code of Virginia, a person who knowingly and intentionally fails to make the report required pursuant to § 63.2-1509 of the Code of Virginia shall be guilty of a Class 1 misdemeanor.

3.3.1.1 Who are mandated reporters?

The Code of Virginia identifies those persons who are mandated reporters. These persons shall report suspected abuse or neglect that they suspect when in their professional or official capacity.

Mandated reporter training and other resources for mandated reporters are available from VDSS on the VDSS public website.

(§ 63.2-1509 A of the Code of Virginia). The following persons who, in their professional or official capacity, have reason to suspect that a child is an abused or neglected child, shall report the matter immediately, except as hereinafter provided, to the local department of the county or city wherein the child resides or wherein the

abuse or neglect is believed to have occurred or to the Department's toll free child abuse and neglect hotline:

1. Any person licensed to practice medicine or any of the healing arts;

2. Any hospital resident or intern, and any person employed in the nursing profession;

3. Any person employed as a social worker or family services specialist;

4. Any probation officer;

5. Any teacher or other person employed in a public or private school, kindergarten or nursery school;

6. Any person providing full-time or part-time child care for pay on a regularly planned basis;

7. Any mental health professional;

8. Any law-enforcement officer or animal control officer;

9. Any mediator eligible to receive court referrals pursuant to § 8.01-576.8;

10. Any professional staff person, not previously enumerated, employed by a private or state-operated hospital, institution or facility to which children have been committed or where children have been placed for care and treatment;

11. Any person, 18 years of age or older, associated with or employed by any public or private organization responsible for the care, custody or control of children; and

12. Any person who is designated a court-appointed special advocate pursuant to Article 5 (§ 9.1-151 et seq.) of Chapter 1 of Title 9.1.

13. Any person, 18 years of age or older, who has received training approved by the Department of Social Services for the purposes of recognizing and reporting child abuse and neglect.

DRAFT

14. Any person employed by a local department as defined in § 63.2-100 who determines eligibility for public assistance.

15. Any emergency medical services provider certified by the Board of Health pursuant to § 32.1-111.5, unless such provider immediately reports the matter directly to the attending physician at the hospital to which the child is transported, who shall make such report forthwith;

16. Any athletic coach, director or other person 18 years of age or older employed by or volunteering with a public or private sports organization or team;

17. Administrators or employees, 18 years of age or older, of public or private day camps, youth centers and youth recreation programs;

18. Any person employed by a public or private institution of higher education other than an attorney who is employed by a public or private institution of higher education as it relates to information gained in the course of providing legal representation to a client; and

19. Any minister, priest, rabbi, imam, or duly accredited practitioner of any religious organization or denomination usually referred to as a church unless the information supporting the suspicion of child abuse or neglect (i) is required by the doctrine of the religious organization or denomination to be kept in a confidential manner or (ii) would be subject to § 8.01-400 or 19.2-271.3 if offered as evidence in court.

20. Any person who engages in the practice of behavior analysis, as defined in § 54.1-2900.

Foster and adoptive parents and respite providers are considered mandated reporters due to their association with a public organization that is responsible for the care, custody and control of children as referenced in § 63.2-1509 A11.

DRAFT

3.3.1.2 Certain mandated reporters may make a report to the person in charge or their designee

The VAC allows certain mandated reporters to make a report to the person in charge or a designee. If the report is made to another person, that person must report back to the original mandated reporter 1) when the report was made; 2) who received the report; and 3) relay any further information back to the original reporter, including any final notifications.

3.3.1.3 Mandated reporter shall disclose all relevant information even if not the complainant

The Code of Virginia § 63.2-1509 A specifies when a mandated reporter makes a report of suspected abuse or neglect; the reporter shall disclose all the information that is the basis of the report to the LDSS. This includes any records or reports documenting the basis of the allegation.

All mandated reporters, even if they are not the complainant, shall cooperate with the LDSS and shall make related information, records and reports about the child who is the subject of the report available to the LDSS for the purpose of validating a CPS referral and for completing a CPS response unless such disclosure violates the federal Family Educational Rights and Privacy Act (20 U.S.C. § 1232(g)).

Provision of such information, records, and reports by a health care provider shall not be prohibited by the Code of Virginia § 8.01-399.

Criminal investigative reports received from law-enforcement agencies shall not be further disseminated by the investigating agency nor shall they be subject to public disclosure.

Although obtaining parental consent to obtain information is always preferable, consent is not required for the release of information for the purpose of validating a referral or completing an investigation or family assessment.

DRAFT

3.3.1.4 Failure by mandated reporter to report abuse or neglect

According to the Code of Virginia § 63.2-1509 D**,** a person required to report who fails to do so as soon as possible, but **not longer than 24 hours** after having a reason to suspect a reportable offense of child abuse or neglect shall be fined not more than $500 for the first failure and for any subsequent failures not less than $1000. If the LDSS becomes aware of an incident involving a mandated reporter who failed to report pursuant to the Code of Virginia § 63.2-1509 A and B, the LDSS must report the incident to the local Commonwealth's Attorney.

If a person knowingly and intentionally fails to report cases involving rape, sodomy, or object sexual penetration, they shall be guilty of a Class 1 misdemeanor.

If a person has actual knowledge that the same matter has already been reported they are not required to contact the LDSS or the state hotline.

3.3.1.5 Physicians reporting venereal disease

Physicians who diagnose venereal disease in a child 12 years of age or under shall make a CPS report to the LDSS. Physicians need not report cases of venereal disease when they reasonably believe that the infection was caused congenitally or by means other than sexual abuse. The Code of Virginia § 32.1-36 A provides that practicing physicians and laboratory directors shall report patients' diseases as prescribed by the State Board of Medicine. See the Code of Virginia § 32.1-36 A and B.

3.3.1.6 Mandated reporters may make report electronically

Mandated reporters may make a report of suspected child abuse or neglect electronically on the Mandated Reporter online portal, VaCPS.

3.3.2 Other persons may make a report of alleged child abuse or neglect

(22 VAC 40-705-40 B). Persons who may report child abuse or neglect include any individual who suspects that a child is being abused or neglected pursuant to § 63.2-1510 of the Code of Virginia.

Any individual suspecting that a child is abused or neglected may make a complaint to the VDSS or to an LDSS. The person can make the complaint to the LDSS in the county or city where the alleged victim child resides or where the alleged abuse or neglect occurred. The person may also make the complaint by calling the CPS State Hotline (**1-800-552-7096**).

3.3.3 Complaints and reports may be made anonymously

> (22 VAC 40-705-40 C). Complaints and reports of child abuse or neglect may be made anonymously.

Reports or complaints alleging abuse or neglect may be made anonymously and the LDSS cannot require the individual to reveal his identity as a condition of accepting the report. All reports shall be documented in the child welfare information system and evaluated for validity and a CPS response regardless of whether or not the caller is identified.

3.3.4 Issues related to reporting

3.3.4.1 Immunity from liability for persons making a report

> (22 VAC 40-705-40 D). Any person making a complaint or report of child abuse or neglect shall be immune from any civil or criminal liability in connection therewith, unless it is proven that such person acted in bad faith or with malicious intent pursuant to § 63.2-1512 of the Code of Virginia.

The following persons are immune from any civil or criminal liability unless it is proven that such person acts with malicious intent:

- Any person making a report or complaint of child abuse or neglect.
- Any person who participates in a judicial proceeding resulting from either making a report or taking a child into immediate custody.

DRAFT

3.3.4.2 Protecting the identity of the reporter or complainant

> (22 VAC 40-705-40 E). When the identity of the reporter is known to the department or local department, these agencies shall not disclose the reporter's identity unless court ordered or required under § 63.2-1503 D of the Code of Virginia.

When the complainant is known to the LDSS, the LDSS shall not disclose the complainant's name. However, the complainant shall also be informed that his anonymity cannot be assured if the case is brought into court or shared with local law enforcement.

3.4 Actions upon receipt of complaint or report

3.4.1 Statutory authorities and responsibilities

The Code of Virginia § 63.2-1503 requires an LDSS to determine the validity of all reports and to decide whether to conduct a family assessment or an investigation, if valid.

3.4.2 Document receipt of complaint or report in child welfare information system

Pursuant to § 63.2-1505 B 2 of the Code of Virginia, when a complaint or report alleging abuse or neglect is received, the LDSS shall enter the report into the child welfare information system.

3.4.3 LDSS shall record all complaints and reports in writing

> (22 VAC 40-705-50 A). All complaints and reports of suspected child abuse or neglect shall be recorded in the child abuse and neglect information system and either screened out or determined to be valid upon receipt. A record of all reports and complaints made to a local department or to the *department that were not valid* shall be purged one year after the date of the report or complaint unless a subsequent report or complaint is made.

All complaints or reports made to the VDSS or an LDSS shall be documented in the child welfare information system. A person may make the initial complaint or report alleging abuse or neglect orally, in writing, or online on the Mandated Reporter

website. The LDSS must document the report or complaint in the child welfare information system within **three working days**, regardless of whether the complaint or report is determined to be valid or invalid. Timeliness of the initial response is calculated from the date and time the referral was received, not validated or assigned.

3.4.3.1 New allegations in an existing family assessment or investigation

When a report has been accepted as valid and the investigation or family assessment response is initiated and subsequent allegations are made, the type of allegation and the time elapsed since the initial report will determine whether the new allegation is treated as a new report or assessed within the context of the existing response. If the allegations do not provide any new or different information, they may be added into the initial investigation or family assessment. If the additional allegations address new types of abuse or neglect and **five (5) or more days** have elapsed since the first report, the additional allegations should be taken as a new report and screened using the CPS Intake Tool.

3.4.3.2 New report in an in-home services case

When child abuse or neglect allegations are made in an open in-home services case, the report must be treated as a new CPS report and evaluated for validity, track, and response priority. This includes situations where safety concerns necessitate the removal of a child. The LDSS may decide to have the In-Home Services worker respond to a valid report if that worker is qualified as a Family Services Specialist who has received the mandated training for CPS as outlined in Section 1, Introduction to CPS. The referral and results of a valid report shall be documented in the child welfare information system as a family assessment or an investigation.

If as a result of the new investigation or family assessment a new safety plan is implemented, it must be shared with all involved parties in the in-home services case. When a new Family Risk Assessment is completed, the service plan must be re-evaluated outside of the normal schedule if safety, risk, or family circumstances change. In addition, a Risk Reassessment must be completed before renewing or ending a service plan.

DRAFT

3.5 Determine validity of complaint or report

When an LDSS receives a report or complaint of abuse or neglect, the LDSS must determine whether the complaint or report is valid upon receipt of the complaint. Criteria are established for determining whether a complaint or report is valid. Each criterion must be satisfied before a complaint or report can be valid. Only valid reports or complaints of abuse or neglect shall receive a family assessment or an investigation. It is important to make the validity decision as soon as possible after the report has been received so that the urgency of the response can be accurately determined. Response time is calculated from the date and time the referral was received, not validated or assigned.

When determining validity, the LDSS must use the CPS Intake Tool for all reports of child abuse and neglect including new reports during open cases. The CPS Intake Tool must be completed in the child welfare information system as soon as possible, but **no later than three working days**, upon receipt of the report by the LDSS. It is critical that the intake worker using the CPS Intake Tool review the definitions available on the tool when making selections on the checklist. Selections made on the CPS Intake Tool must relate to supporting narrative in the child welfare information system. The CPS Intake Tool with definitions is located on the forms page on the DSS public website.

The CPS Intake Tool is covered in Module 1 of the e-learning course CWSE1510: Structured Decision Making in Virginia located in the VLC.

3.5.1 Definition of valid complaint or report

The Code of Virginia § 63.2-1508 defines a valid complaint.

> *(§ 63.2-1508). A valid report or complaint means the local department has evaluated the information and allegations of the report or complaint and determined that the local department shall conduct an investigation, family assessment, or human trafficking assessment because the following elements are present:*
>
> 1. The alleged victim child or children are under the age of 18 years at the time of the complaint or report;

2. The alleged abuser is the alleged victim child's parent or other caretaker; *or, for purposes of abuse or neglect described in subdivision 4 of the definition of "abused or neglected child" in § 63.2-100, an intimate partner of such parent or caretaker*;

3. The local department receiving the complaint or report has jurisdiction; and

4. The circumstances described allege suspected child abuse or neglect as defined in § 63.2-100 of the Code of Virginia.

3.5.2 Determine whether the complaint or report is valid

There are four criteria that must be addressed when determining whether the complaint or report is valid. Each question must be satisfied in order to have a valid report. The four elements are:

3.5.2.1 Question 1: Is the alleged victim child under eighteen years of age?

(22 VAC 40-705-50 B 1). The alleged victim child or children are under the age of 18 years at the time of the complaint or report.

The LDSS can only respond with a family assessment or an investigation to valid complaints or reports involving children less than 18 years of age at the time of the report or complaint. If the alleged victim is over 18 years of age, the LDSS should refer that person to the local attorney for the Commonwealth, Adult Protective Services, or other appropriate services provided in the locality.

3.5.2.1.1 Emancipated minor

If the alleged victim child is under 18 years of age and has been legally emancipated, then the LDSS has the discretion of not completing a family assessment or investigating the complaint.

The LDSS may determine a report of abuse or neglect as invalid if a court has emancipated the alleged victim of the abuse or neglect pursuant to the Code of Virginia §§ 16.1-331 and 16.1-332.

The Code of Virginia §§ 16.1-331, 16.1-332, and 16.1-333 require petitioning the juvenile court and the court conducting a hearing before making a finding of emancipation. The LDSS must confirm that the child has been legally emancipated before invalidating the complaint or report.

3.5.2.1.2 Alleged victim child is married

There is no specific Code of Virginia or VAC provision prohibiting the validation of a complaint involving an alleged victim child who is married. When an LDSS receives a complaint involving a married child, the first issue the LDSS may address is whether the alleged victim child is emancipated. If the alleged victim child is married and emancipated, then the LDSS should invalidate the complaint or report.

A husband or wife of the alleged victim cannot be considered a caretaker.

3.5.2.2 Question 2: Is the alleged abuser or neglector a caretaker?

> (22 VAC 40-705-50 B 2). The alleged abuser is the alleged victim child's parent or other caretaker.

The second element of a valid complaint is the alleged abuser or neglector must be a caretaker. The VAC defines caretaker:

> (22 VAC 40-705-10) "Caretaker" means any individual having the responsibility of providing care and supervision of a child and includes the following: (i) parent or other person legally responsible for the child's care; (ii) an individual who by law, social custom, expressed or implied acquiescence, collective consensus, agreement or any other legally recognizable basis has an obligation to look after a child left in his care; and (iii) persons responsible by virtue of their conferred authority.

A caretaker is an individual who is responsible or assumes responsibility for providing care and supervision for the child. There are three (3) general categories of caretakers:

- A parent or other person legally responsible for the child's care includes:

- Birth parent.
- Adoptive parent.
- Stepparent.
- Legal guardian.
- Foster parent.

- An individual who by law, social custom, expressed or implied acquiescence, collective consensus, agreement or any other legally recognizable basis has an obligation to look after the child left in their care may include but is not limited to:
  - Relative.
  - Babysitter.
  - Paramour of the parent.
  - Cohabitants.

For all such individuals in this category, the LDSS must be able to document how the care and control of the child was expressly delegated or implied to the individual, as well as take into consideration the factors listed in 3.5.2.2.1. For example, a person who merely resides in the same home as the child but was never delegated any authority over the child and in fact did not exercise any control over the child is not a caretaker. (Moore v. Brown, 2014 Va. App. LEXIS 181.)

- Individuals responsible by virtue of their positions of conferred authority includes but is not limited to:
  - Teacher or other school personnel.
  - Institutional staff.
  - Child care personnel.

DRAFT

- Scout troop leaders.

3.5.2.2.1 Caretaker considerations

When determining whether a person is responsible for the care of a child, the LDSS should consider the amount of authority for the care, control and discipline of the child delegated to the person acting as a caretaker. The LDSS should gather sufficient evidence to demonstrate that the alleged abuser/neglector is a caretaker and document such evidence in the child welfare information system. The LDSS should consider these issues when determining whether a person is a caretaker.

- What is the person's relationship with the child?
- What is that person's role or function toward the child?
- Was the person in a caretaking role at the time of the alleged abusive or neglectful incident?
- Was the primary responsibility of the person toward the child one of supervision and providing care, or was the person providing a professional or expert service?
- How do the child and the child's usual caretaker view this relationship and role?
- How does the community view this relationship and role?
- Have the parents or other person specifically delegated formally or informally the caretaking role for this person?
- What were the expectations of the parent, alleged abuser/neglector and child?

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3.5.2.2.2 Caretakers less than 18 years of age

The LDSS should consider these additional issues when determining if a minor is a caretaker:

- Was it appropriate for the minor to have been put in a caretaking role?
- Was the alleged abuse or neglect by the minor indicative of their own abuse? (i.e., sexual knowledge or behavior that is age inappropriate)
- What is the age difference between the alleged abuser and the victim; was this peer interaction?

If it is determined that a minor may have abused or neglected a child but the minor should not have been placed in a caretaker role, the LDSS may determine the minor to be the victim child of the caretaker who put them in that role. If it is determined that a minor may have sexually abused the child and the minor is not determined to be a caretaker, refer to section 3.5.5.2 for additional guidance on reporting non-caretaker sexual abuse.

Refer to Section 4, Family Assessment and Investigation and Section 7, Appeals for additional guidance regarding caretakers under 18 years of age.

3.5.2.2.3 Caretakers in complaints or reports alleging the human trafficking of a child

> (§ 63.2-1508 B of the Code of Virginia). A valid report or complaint regarding a child who has been identified as a victim of sex trafficking or severe forms of trafficking as defined in the federal Trafficking Victims Protection Act of 2000 (22 U.S.C § 7102 et seq.) and in the federal Justice for Victims of Trafficking Act of 2015 (P.L. 114-22) may be established *regardless of who* the alleged abuser is *or whether the alleged abuser has been identified.*

The alleged victim child's parent, other caretaker, or any other person, *even if they have not been identified*, suspected to have abused or neglected the

child may be considered a caretaker when evaluating the validity of a complaint or report involving the alleged human trafficking of the child.

3.5.2.2.4 Caretakers in complaints or reports alleging the sexual abuse or sexual exploitation of a child.

Pursuant to § 63.2-1508 of the Code of Virginia, the alleged victim child's parent, other person responsible for their care, or an intimate partner of such parent or person may be considered a caretaker when evaluating the validity of a complaint or report involving the alleged sexual abuse or sexual exploitation of a child.

3.5.2.3 Question 3: Is abuse or neglect alleged to have occurred?

> (22 VAC 40-705-50 B 4). The circumstances described allege suspected child abuse or neglect as defined in § 63.2-100 of the Code of Virginia.

The complaint or report must describe a type of abuse or neglect as defined in 22 VAC 40-705-30 or Section 2, Definitions of Abuse and Neglect of this guidance manual.

3.5.2.3.1 General factors to consider when determining if abuse or neglect definition has been met

The Family Services Specialist must consider the following questions to determine if the definition of physical abuse has been met.

- What was the action or inaction of the caretaker?
- Did the child sustain an injury or is there evidence establishing that the child was threatened with sustaining an injury?
- Does the evidence establish a nexus, or causal relationship between the action or inaction of the caretaker and the physical injury or threatened physical injury to the child?
- Was the injury, or threat of injury, caused by non-accidental means?

3.5.2.3.2 Establish injury or threat of an injury

The report or complaint must allege a threat of injury or actual injury to the child to satisfy the definition of abuse or neglect. The Code of Virginia and the VAC do not require that the child sustain an actual injury.

3.5.2.3.3 Establish nexus between caretaker's actions or inaction and the injury or threatened injury to the child

The complaint or report must allege a link between the actions or inaction of the caretaker, regardless of the caretaker's intent, and the injury to the child or the threat of injury to the child.

3.5.2.3.4 "Other than accidental means"

The injury or threat of injury to the child must have occurred as a result of "other than accidental means." The caretaker's actions must be carefully considered when determining whether the injury or threat of injury sustained by the child was caused accidentally.

For example, the complaint alleged that the caretaker caused bruises and abrasions on the child's ankles and wrists. The caretaker asserted that he did not intend to cause the injuries to the child; he intended to restrain the five-year-old boy with a rope. However, the evidence shows that the caretaker tied the child's legs at the ankles and tied the wrists to a chair, and when the child jerked in several different directions for over 20 minutes to try to get loose, injuries occurred to these parts of the body. The caretaker did not accidentally tie the child and leave him for 20 minutes. Although the caretaker did not intend to cause the injuries to the child, the caretaker did intend to tie the child, and could reasonably expect this child would try to get loose. The caretaker's act of restraining this child with a rope was intended and could have caused more serious harm. The result of the caretaker's actions was not unforeseen or unexpected. Therefore, the injury was not accidental.

In the alternative, a black eye to the child's face while playing catch with the caretaker would be considered accidental. The fact that the ball bounced off the child's mitt and struck the child's eye was not intended. In the first

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example, the caretaker intended to discipline his child by restraining with a rope for 20 minutes. The intended act of restraining the child caused the injury to the child. In the second example, the caretaker did not intend for the ball to bounce off the child's mitt and hit the child's face. The action causing the black eye was accidental.

3.5.2.3.5 Determine if medical neglect definition has been met

It is the parent's responsibility to determine and obtain appropriate medical, mental health and dental care for a child. What constitutes adequate medical treatment for a child cannot be determined in a vacuum free of external influences, but rather, each case must be decided on its own particular facts. The focus of the CPS response are whether the caretaker failed to provide medical treatment and whether the child was harmed or placed at risk of harm as a result of the failure. Cultural and religious child-rearing practices and beliefs that differ from general community standards should not be considered a basis for medical neglect, unless the practices present a specific danger to the physical or emotional safety of the child.

- **Treatment or care must be necessary**. The statutory definition of medical neglect requires that the parent neglects or refuses to provide necessary care for the child's health. Therefore, the LDSS must establish that the caretaker's failure to follow through with a complete regimen of medical, mental health or dental care for a child was necessary for the child's health. The result of the caretaker's failure to provide necessary care could be illness or developmental delays. The challenging issue is determining when medical care is necessary for the child's health. Obviously, life-saving medical treatment is necessary and falls within the definition. However, when parents or caretakers refuse medical care that is important to their child's well-being but is not essential to life, the issue becomes more complicated in determining whether the medical care is necessary.

- **Assess degree of harm (real or threatened) to the child**. When assessing whether the medical, mental health or dental treatment is necessary for the child's health, the LDSS should consider the degree

of harm the child suffered as a result of the lack of care. If the child has yet to suffer harm, then the LDSS should assess the likelihood that the child will suffer harm. The greater the harm, the more necessary the treatment.

- In addition to harm, the LDSS should consider the type of medical, mental health or dental condition involved and whether the condition is stable or progressive. Whether the condition is stable or progressive may be an issue in determining the severity of the condition and the necessity of treatment. If the condition of the child is stable, then the LDSS may consider deferring to the caretaker's authority. If the condition is progressive and left untreated, then the LDSS may give lesser deference to the caretaker's authority.

  - **Parent refuses treatment for life-threatening condition**. Pursuant to the Code of Virginia § 63.2-100, a parent's decision to refuse a particular medical treatment for a child with a life-threatening condition shall not be deemed a refusal to provide necessary care when all the following conditions are met:

    - The decision is made jointly by the child and the parents or other person legally responsible for the child.
    - The child has reached 14 years of age and sufficiently mature to have an informed opinion on the subject of his medical treatment.
    - The child and the parents or other person legally responsible for the child have considered alternative treatment options.
    - The child and the parents or other person legally responsible for the child believe in good faith that such decision is in the child's best interest.

The VAC provides definitions of some of the terms in the Code of Virginia.

(22 VAC 40-705-10). "Particular medical treatment" means a process or procedure that is recommended by conventional medical providers and accepted by the conventional medical community.
"Sufficiently mature" is determined on a case-by-case basis and means that a child has no impairment of his cognitive ability and is of a maturity level capable of having intelligent views on the subject of his health condition and medical care.
"Informed opinion" means that the child has been informed and understands the benefits and risks, to the extent known, of the treatment recommended by conventional medical providers for his condition and the alternative treatment being considered as well as the basis of efficacy for each, or lack thereof.
"Alternative treatment options" means treatments used to prevent or treat illnesses or promote health and well-being outside the realm of modern conventional medicine.
"Life-threatening condition" means a condition that if left untreated more likely than not will result in death and for which the recommended medical treatments carry a probable chance of impairing the health of the individual or a risk of terminating the life of the individual.

- **Assess caretaker's rationale**. The most singular underlying issue in determining whether a child is being deprived of adequate medical care, and therefore, a medically neglected child, is whether the parents have provided an acceptable course of medical treatment for their child in light of all the surrounding circumstances. The LDSS should consider whether the caretaker's failure to provide necessary medical treatment was caused by ignorance or misunderstanding. The LDSS should consider whether the caretakers obtained accredited medical assistance and were aware of the seriousness of their child's condition. The LDSS should weigh the possibility of a cure if a certain mode of treatment is undertaken and whether the caretakers provided their child with a treatment. The LDSS should consider whether the caretakers sought an alternative treatment recommended by their physician and have not totally rejected all responsible medical authority.

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- **Assess financial capabilities and poverty**. The LDSS should consider whether the caretaker's failure to provide necessary medical treatment was caused by financial reasons or poverty. Parents or caretakers should not be considered neglectful for the failure to provide necessary medical treatment unless they are financially able to do so or were offered financial or other reasonable means to do so. In such situations, a founded disposition may be warranted if, after appropriate counseling and referral, the parents still fail to provide the necessary medical care.

3.5.2.3.6 Child under alternative treatment

> (22 VAC 40-705-30 B3b(1)). A child who, in good faith, is under treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination, shall not for that reason alone be considered a neglected child in accordance with § 63.2-100 of the Code of Virginia.

The Code of Virginia provides that no child shall be considered an abused or neglected child only for the reason that the child is under treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination. The religious exemption to a founded disposition of child abuse or neglect mirrors the statute providing a religious defense to criminal child abuse and neglect.[1] This exemption means that a founded disposition cannot be based only upon the religious practices of the parents or caretakers. A founded disposition can be rendered for other reasons. For example, if the parent caused the injury in the first place, the religious exemption would not apply. The religious exemption to a founded disposition of abuse or neglect is designed to protect a family's right to

[1] See § 18.2-371.1C of the Code of Virginia. Any parent, guardian or other person having care, custody, or control of a minor child who in good faith is under treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination shall not, for that reason alone, be considered in violation of this section.

freedom of religion. The religious exemption statute is not to provide a shield for a person to abuse or neglect a child.[2]

Should there be question concerning whether a child is under the treatment in accordance with a tenet or practice of a recognized church or religious denomination, the LDSS should seek the court's assistance. The court should decide whether the parent or caretaker is adhering to religious beliefs as the basis for refusal of medical or dental treatment.

3.5.2.3.7 Medical neglect of infants with life-threatening conditions

The Virginia Administrative Code 22 VAC 40-705-30 B3 states that medical neglect includes withholding of medically indicated treatment. The definition section of 22 VAC 40-705-10 et seq. defines withholding of medically indicated treatment as specific to infants. When conducting an investigation involving an infant deprived of necessary medical treatment or care, the LDSS must be aware of the ancillary definitions and guidance requirements.

> (22 VAC 40-705-10). "Withholding of medically indicated treatment" means the failure to respond to the infant's life-threatening condition by providing treatment (including appropriate nutrition, hydration, and medication) which in the treating physician's or physicians' reasonable medical judgment will be most likely to be effective in ameliorating or correcting all such conditions.

This definition applies to situations where parents do not attempt to get a diagnosis even when the child's symptoms are severe and observable.

- **Withholding of medically indicated treatment when treatment is futile**.

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[2] The United States Supreme Court held in 1944 that "parents may be free to become martyrs themselves. But it does not follow that they are free, in identical circumstances, to make martyrs of their children before they can reach the age of full and legal discretion when they can make that choice for themselves." *Prince v. Massachusetts*, 321 U.S. 158, 170 (1944).

(22 VAC 40-705-30 B3b(2)). For the purposes of this chapter, "withholding of medically indicated treatment" does not include the failure to provide treatment (other than appropriate nutrition, hydration, or medication) to an infant when in the treating physician's or physicians' reasonable medical judgment:
a. The infant is chronically and irreversibly comatose;
b. The infant has a terminal condition and the provision of such treatment would (i) merely prolong dying; (ii) not be effective in ameliorating or correcting all of the infant's life-threatening conditions; (iii) otherwise be futile in terms of the survival of the infant; or (iv) be virtually futile in terms of the survival of the infant and the treatment itself under such circumstances would be inhumane.

- **Definition of chronically and irreversibly comatose and terminal condition.**

(22 VAC 40-705-10). "Chronically and irreversibly comatose" means a condition caused by injury, disease or illness in which a patient has suffered a loss of consciousness with no behavioral evidence of self-awareness or awareness of surroundings in a learned manner other than reflexive activity of muscles and nerves for low-level conditioned response and from which to a reasonable degree of medical probability there can be no recovery.
(22 VAC 40-705-10). "Terminal condition" means a condition caused by injury, disease or illness from which to a reasonable degree of medical probability a patient cannot recover and (i) the patient's death is imminent or (ii) the patient is chronically and irreversibly comatose.

3.5.2.3.8 Screening decision for substance-exposed infant (SEI) reports

A report of an SEI, which meets one of the three circumstances outlined in § 63.2-1509 of the Code of Virginia, is sufficient to initiate a CPS response. However, if a report of SEI is made by a healthcare provider and screened out, the LDSS should advise the caller to refer the mother and child to the local Community Services Board (CSB), Opioid Treatment Program, Medication Assisted Treatment provider, home visiting program and/or local public health department to ensure a Plan of Safe Care is developed for the mother and child. See Section 10: Substance-Exposed Infants for specific guidance relating to this special population.

3.5.2.4 Question 4: Does the LDSS have jurisdiction to conduct the family assessment or investigation?

The Code of Virginia § 63.2-1503 A provides the LDSS with the jurisdictional authority to conduct investigations of reports or complaints alleging child abuse and neglect. Jurisdiction determines which LDSS has primary responsibility for responding to a complaint or report of abuse or neglect.

The LDSS that first receives a report or complaint must determine if they have jurisdiction and which LDSS is the local department of jurisdiction.

The VAC defines local department of jurisdiction as:

> (22 VAC 40-705-10). "Local department of jurisdiction" means the local department in the city or county in Virginia where the alleged victim child resides or in which the alleged abuse or neglect is believed to have occurred. If neither of these is known, then the local department of jurisdiction shall be the local department in the county or city where the abuse or neglect was discovered.

If the LDSS that first receives a complaint or report of child abuse or neglect has jurisdiction, that local department becomes the local department of jurisdiction and shall assume responsibility to determine the validity of the complaint or report; and, if valid, shall ensure that a family assessment or investigation is conducted.

> (§ 63.2-1508 D). *If the local department receiving the complaint or report does not have jurisdiction, and the local department that has jurisdiction to investigate such complaint or report is located in the Commonwealth, the local department that received the report or complaint shall forward the complaint or report to the appropriate local department.*

If the LDSS that first receives a complaint or report of child abuse or neglect does not have jurisdiction, that local department must determine the local department of jurisdiction and **immediately** do each of the following:

- Document and transfer the complaint or report in the child welfare information system.

- Make verbal contact with a Family Services Specialist or Supervisor at the local department of jurisdiction and advise them of the transfer.

- Advise the person making the complaint or report of the name and telephone number for the local department of jurisdiction.

Only a local department of jurisdiction may determine the validity of a complaint or report of child abuse or neglect; and, if valid, conduct an investigation or family assessment.

If the criteria for where the abuse or neglect occurred and where the child resides are different, the priority for the local department of jurisdiction should be given to the jurisdiction where the abuse or neglect occurred only if there is a joint investigation with law enforcement in that jurisdiction associated with the allegations. Otherwise, the local department of jurisdiction should be where the child resides to ensure the provision of services to the child and family.

Two local departments who cannot agree on jurisdiction must work to resolve the jurisdictional issue prior to contacting their Regional Practice Consultant. The resolution process must include a telephone discussion by the Family Services Supervisors at the respective local departments. If it cannot be resolved by the Family Services Supervisors, the next step must include a telephone discussion by the Directors or their designees at the respective local departments. If it cannot be resolved by the Directors or their designees, the local departments must contact their Regional Practice Consultant. The Regional Practice Consultant will then determine which local department must accept jurisdiction.

3.5.2.4.1 Lack of jurisdiction not sufficient to invalidate complaint or report

The LDSS may not invalidate a complaint or report because they are not the local agency of jurisdiction. The LDSS must **immediately** document and transfer the complaint or report in the child welfare information system to the local agency of jurisdiction as instructed in Section 3.5.2.4.

3.5.2.4.2 Out-of-state jurisdiction

If the complaint or report belongs out-of-state, then the LDSS must make a referral to the appropriate agency in the other state, document the referral in the child welfare information system, and then invalidate the referral for lack of jurisdiction in the child welfare information system.

3.5.2.4.3 Transfer jurisdiction of complaint or report to local department of jurisdiction

The LDSS transferring a complaint or report to the local department of jurisdiction must immediately:

- Document and transfer the complaint or report in the child welfare information system;
- Make verbal contact with a Family Services Specialist or Supervisor at the local department of jurisdiction and advise them of the transfer; **AND**
- Advise the person making the complaint of the name and telephone number for the local department of jurisdiction. VDSS maintains a Local Department of Social Services Directory with contact information for each local agency.

The LDSS transferring a complaint or report must do so **immediately** because the receiving local department of jurisdiction is responsible for ensuring the initial response is initiated within the determined response time. See Section 3.8 Screen valid complaints and reports for priority.

3.5.2.4.4 Responsibilities of the local department of jurisdiction receiving the complaint

The local department of jurisdiction receiving a complaint or report shall assume responsibility for determining the validity of the complaint or report; and, if valid, ensure that a family assessment or investigation is conducted.

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The local department of jurisdiction must also ensure the initial response is initiated within the determined response priority.

3.5.2.4.5 Assistance between local department of jurisdiction

> (22 VAC 40-705-40 I 3). A local department of jurisdiction may ask another local department that is a local department of jurisdiction to assist in conducting the family assessment or investigation. If assistance is requested, the local department shall comply.

The local department of jurisdiction may ask another local department of jurisdiction to assist in conducting the CPS family assessment or investigation. Assistance shall be provided upon request. Assistance may include conducting courtesy interviews of the alleged victim child, the alleged victim child's parents or other caretakers, and the alleged abuser or neglector. Assistance may also include arranging for appointments, scheduling meetings, counseling sessions, or any other professional contacts and services for the alleged victim child and siblings, the child's parents or other caretakers, or alleged abuser or neglector.

- When a party relocates outside of the investigating LDSS's jurisdiction. The Code of Virginia § 63.2-1503 H specifically addresses the circumstances when a party to a report or complaint of abuse or neglect relocates outside of the jurisdiction of the investigating LDSS.

- When the alleged victim child, and/or the child's parents or other caretakers who are the subject of the family assessment or investigation relocate out of the jurisdiction of the LDSS responsible for the family assessment or investigation, the LDSS of jurisdiction shall notify the CPS Unit of the LDSS where the parties relocated, whether inside or outside of Virginia. The LDSS of jurisdiction may seek assistance from the other LDSS in completing the investigation. The notified LDSS shall respond to the receiving LDSS's request for assistance in completing the family assessment or investigation. Any LDSS in Virginia so requested shall comply.

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- LDSS shall share relevant case record information. When one local department of jurisdiction requests another local department of jurisdiction to assist in completing a family assessment or an investigation or providing services, the requesting local department of jurisdiction shall contact the receiving local department of jurisdiction by telephone before transferring the record within the child welfare information system. The receiving local department of jurisdiction shall then arrange protective and rehabilitative services as needed or appropriate, and assist in a timely completion of the investigation or family assessment. All written notification and letters (i.e., disposition letters and notification of appeal rights) remain the responsibility of the original local department of jurisdiction conducting the family assessment or investigation. The local department of jurisdiction shall continue to retain case materials not entered into the child welfare information system and provide the receiving local department of jurisdiction with relevant portions of the case record necessary to provide services or to complete the investigation or family assessment.

> (22 VAC 40-705-40 I4). A local department of jurisdiction may ask another local department through a cooperative agreement to assist in conducting the family assessment or investigation.

- **Cooperative agreements between LDSS**. A local department of jurisdiction may request assistance from a local department that is not necessarily a local department of jurisdiction. A cooperative agreement may be developed between the two LDSS to address guidelines, parameters, and follow-up requirements.

3.5.2.4.6 The appearance of a conflict of interest

Family assessments or investigations involving recognized figures, local or county officials, former employees, and other persons who are well known within the community may raise the appearance of a conflict of interest for an LDSS.

In order to assure that the response to such cases is and appears to be impartial, the local department of jurisdiction may contact a neighboring locality and develop the appropriate guidelines for completion of the family assessment or investigation. The LDSS may develop a cooperative agreement to ensure that the report receives an appropriate response.

The local department of jurisdiction should request a neighboring locality to conduct any investigation in reports involving a foster child when the child is placed in a locally approved foster home.

When considering transferring a report or complaint of child abuse or neglect because of the appearance of a conflict of interest, the LDSS may seek guidance from the CPS Regional Consultant.

3.5.2.4.7 Family assessments or investigations involving employees of LDSS

The Code of Virginia § 63.2-1509 provides the juvenile and domestic relations district court the authority to determine jurisdiction of the investigation if the alleged abuser or neglector is an employee of the LDSS where the report or complaint was received. The purpose of this statute is to ensure a fair investigation and preserve impartiality.

The VAC states:

> (22 VAC 40-705-40 H4). If a local department employee is suspected of abusing or neglecting a child, the complaint or report of child abuse or neglect shall be made to the juvenile and domestic relations district court of the county or city where the alleged abuse or neglect was discovered. The judge shall assign the report to a local department that is not the employer of the subject of the report, or, if the judge believes that no local department in a reasonable geographic distance can be impartial in responding to the reported case, the judge shall assign the report to the court service unit of his court for evaluation pursuant to §§ 63.2-1509 and 63.2-1510 of the Code of Virginia. The judge may consult with the department in selecting a local department to respond.

- **Jurisdiction: assignment of investigation by court to LDSS**. If a LDSS is assigned a report by the court, the family assessment or investigation should be conducted like any other.

3.5.2.4.8 LDSS cannot assume jurisdiction if abuse or neglect occurred in another state and the alleged abuser does not reside in Virginia

A LDSS shall not assume jurisdiction of an investigation or family assessment if the alleged abuse or neglect occurred in another state and the alleged abuser does not reside in Virginia, even if the alleged victim resides in Virginia at the time of the report. A LDSS should report the suspected abuse or neglect to CPS in the state where the abuse or neglect occurred. If the other state requests assistance in conducting the investigation or family assessment, the LDSS should comply. If services are needed for the child or family, the LDSS may open the case for services.

- **Transfer jurisdiction of investigation to another state**. If appropriate, the LDSS may request the other state to assume jurisdiction of the investigation. If the other state agrees to assume jurisdiction of the investigation, the LDSS should provide all information relevant to the investigation to the other state. The following information should be provided when making a referral:
  - The name, date of birth, and sex of child.
  - Any other name by which the child may be known.
  - The names of parent and/or guardian.
  - Any other names by which the parent and/or guardian may be known.
  - The current address including any directions.
  - Last known address.
  - Statement of why the referral is being made.
  - Brief social history of the child and the family.

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- A brief description of the LDSS's involvement with the family.

3.5.3 Universal screening for domestic violence (DV)

All valid reports should be screened to determine the presence of DV. There are several evidence based tools that can be used to screen for DV depending on who is being interviewed. The "HITS" (Hurt, Insult, Threaten, Scream) screening tool may be used to screen for DV with collaterals such as family members, professionals, service providers, anonymous callers and mandated reporters. The Women's Experience with Battering Tool (WEB) is designed to be used with potential victims of DV. These screening tools and additional guidance regarding DV and universal screening can be found in a new section of the VDSS Child and Family Services Manual, Chapter H. Domestic Violence.

3.5.4 Invalid report or complaint

> (22 VAC 40-705-50 C). The local department shall not conduct a family assessment or investigate complaints or reports of child abuse or neglect that fail to meet all of the criteria in subsection B of this section.

Each of the four criteria outlined in 22 VAC 40-705-50 B must be satisfied in order to achieve a valid complaint of abuse or neglect requiring a family assessment or an investigation. If the complaint or report of abuse or neglect fails to meet any one of the criteria, then the complaint or report is not valid and the LDSS has no authority to conduct a CPS family assessment or an investigation.

3.5.4.1 Additional information for screening reports of abuse or neglect regarding public school personnel

The Code of Virginia § 63.2-1511 states that “reasonable and necessary” force should be taken into account in determining validity of reports of abuse or neglect by public school employees. Appendix A in Section 5: Out of Family Investigations of this guidance manual has additional guidance for assessing the applicability of § 63.2-1511 for CPS out-of-family reports of school employees.

3.5.4.2 Screening consideration if alleged abuser is deceased

If the alleged abuser or neglector is deceased at the time of the report or dies during the course of the investigation, the LDSS must evaluate whether the purpose of the investigation would be achieved. An investigation may be appropriate if there is a child victim in need of services or in order to prevent other abuse or neglect.

If a child death is alleged to have resulted from abuse or neglect by a deceased caregiver, the LDSS should proceed with a child death investigation.

3.5.4.3 Prevention response for invalid report or complaint

If a report or complaint is determined to be invalid and the LDSS has determined that services need to be provided to prevent foster care, the LDSS should open a Prevention services case to provide services to the child and family. The Code of Virginia § 63.2-905 provides the legal authority to offer and provide foster care services, which includes services to a child who is in need of services to prevent or eliminate the need for foster care placement. A child in need of services may include a victim of sex trafficking or non-caretaker sexual abuse.

> (§ 63.2-905 of the Code of Virginia). Foster care services are the provision of a full range of casework, treatment and community services, including but not limited to independent living services, for a planned period of time to a child who is abused or neglected as defined in § 63.2-100 or in need of services as defined in § 16.1-228 and his family when the child (i) has been identified as needing services to prevent or eliminate the need for foster care placement, (ii) has been placed through an agreement between the local board or the public agency designated by the community policy and management team and the parents or guardians where legal custody remains with the parents or guardians, or (iii) has been committed or entrusted to a local board or licensed child placing agency. Foster care services also include the provision and restoration of independent living services to a person who is over the age of 18 years but who has not yet reached the age of 21 years, in accordance with § 63.2-905.1.

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Refer to the VDSS Child and Family Services Manual, Chapter B. Prevention, Section 2, for further guidance regarding prevention services.

3.5.4.4 Universal response to invalid complaints or reports of child human trafficking

All complaints or reports alleging a child is a victim of human trafficking require the LDSS complete a human trafficking assessment, unless during the course of the human trafficking assessment it is determined an investigation or family assessment is required by law or is necessary to protect the safety of the child. The human trafficking assessment response creates a universal response by the child welfare system to the human trafficking of children. The purpose of the human trafficking assessment is to assess both the safety and risk factors associated with the child victim and his family/caretaker(s) as well as the protective and rehabilitative service needs of the child victim and his family/caretaker(s). See Section 4.2 for further guidance regarding the human trafficking assessment.

3.5.5 Required notifications if report or complaint is invalid

3.5.5.1 Notify complainant

If a report is determined to be invalid, the LDSS must inform the complainant of its lack of authority to take action. This notification must be documented in the child welfare information system.

3.5.5.1.1 Invalid complaint involving child care *or residential* facility

If a report is not valid because it addresses general substandard conditions in a child care *or residential* facility, but the conditions do not constitute abuse or neglect, the LDSS shall identify the proper regulatory authority and refer the caller to that regulatory authority. *The LDSS must also notify the proper regulatory authority of the report.* If there is no regulatory authority and no valid complaint for CPS investigation, the caller shall be informed that there is no agency with the authority to intervene.

3.5.5.1.2 Non-caretaker sexual abuse: information to be provided to reporter or complainant

The intake worker should explain the following to the person making the report or complaint alleging the non-caretaker sexual abuse of a child:

- The LDSS is not the agency authorized to investigate the report.
- The LDSS is required to report this information directly to law enforcement.

This includes allegations involving sex trafficking of a child by someone not in a caretaker role.

3.5.5.2 Notify law enforcement of non-caretaker sexual abuse

If a report is not valid because it alleges child sexual abuse perpetrated by a person who is not in a caretaker role, the LDSS is required to report the allegation to the local law enforcement agency. The worker should telephone the information to law enforcement in the jurisdiction where the abuse occurred in accordance with any local protocol or standard procedures for reporting sex offenses involving juvenile victims. If there is any reason to believe a child may be in danger, the report must be made immediately. In all other cases, the report must be made on the **same day** it is received. Additional procedures may be developed locally to ensure effective reporting and accountability.

3.5.5.3 Information to provide to law enforcement in non-caretaker sexual abuse

The intake worker should attempt to obtain as much information about the alleged sexual abuse as possible and forward that information to the local law enforcement agency. The intake worker should attempt to obtain the following information:

- The identity of the child and the identity of the alleged perpetrator (name, birth date, sex, address, child's school).

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- Brief description of the alleged abuse.

3.6 Certain complaints shall be reported to the CA and others

3.6.1 Report certain cases of suspected child abuse or neglect

> (22 VAC 40-705-50 D). The local department shall report certain cases of suspected child abuse or neglect to the local attorney for the Commonwealth and the local law-enforcement agency pursuant to § 63.2-1503 D of the Code of Virginia.

The following complaints and reports shall be reported by the LDSS to the attorney for the Commonwealth and local law enforcement agency **immediately but within two (2) hours** of receipt of the report. The LDSS shall provide records and information, including reports related to any complaints of abuse or neglect involving the victim(s) or the alleged perpetrator, related to the investigation of the complaint. The LDSS must document the date and time of notification to the local attorney for the Commonwealth and the local law enforcement agency in the child welfare information system. This notification should be documented on the referral acceptance screen and in the referral as an Interview and Interaction (I and I).

3.6.1.1 Any death of a child

Any report or complaint alleging the death of a child as a result of abuse or neglect shall be immediately reported to the local attorney for the Commonwealth and the local law-enforcement agency.

See Section 6, Child Deaths, of this guidance manual for additional requirements and guidance related to a report of a child death due to suspected abuse or neglect.

3.6.1.2 Any injury or threatened injury to a child involving a felony or Class I misdemeanor

Any report or complaint involving an injury (actual or threatened) that may have occurred as the result of a commission of a felony or a Class 1 misdemeanor shall be immediately reported to the local attorney for the Commonwealth and

the local law-enforcement agency. Felony offenses are punishable with death or confinement in a state correctional facility; all other offenses are misdemeanors.[3]

Felonies are classified, for the purposes of punishment and sentencing, into six (6) classes; misdemeanors are classified into four (4) classes.[4]

3.6.1.3 Any sexual abuse, suspected sexual abuse or other sexual offense involving a child

Any sexual abuse, suspected sexual abuse, or other sexual offense involving a child, including but not limited to the use or display of the child in sexually explicit visual material, as defined in the Code of Virginia § 18.2-374.1 et seq., shall be reported to the local attorney for the Commonwealth office and local law enforcement agency. This includes criminal acts of commercial sex trafficking as defined in the Code of Virginia §18.2-357.1.

3.6.1.4 Any abduction of a child

Any time a report or complaint alleges the abduction of a child, the LDSS shall make a report to the local attorney for the Commonwealth office and to local law enforcement agency.

3.6.1.5 Any felony or Class 1 misdemeanor drug offense involving a child

Any time a report or complaint alleges abuse or neglect of a child and the commission of a felony or a Class 1 misdemeanor drug offense, the LDSS shall notify the local attorney for the Commonwealth office and local law enforcement agency.

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3 § 18.2-8.of the Code of Virginia.

4 § 18.2-9 of the Code of Virginia.

3.6.1.6 Contributing to the delinquency of a minor

Contributing to the delinquency of a minor in violation of the Code of Virginia § 18.2-371 shall be reported to the local attorney for the Commonwealth office and local law enforcement agency.[5]

3.6.1.7 Information to provide to Commonwealth's Attorney and law-enforcement agency

When making a report to the local attorney for the Commonwealth and local law enforcement agency, the LDSS shall make available all of the information upon which the report is based, including the name of the complainant and records of any complaint of abuse or neglect involving the victim or the alleged perpetrator.

3.6.1.8 Other criminal acts related to child abuse or neglect

Other felonies and misdemeanors, not specifically identified for reporting by the Code of Virginia, may be related to child abuse or neglect. The reporting of these offenses must be in accordance with guidance developed by the LDSS in conjunction with the community's law enforcement and judicial officials.

3.6.2 Notification to law enforcement form

Written notification by the LDSS to the local law enforcement agency shall be made within **two (2) business days** of receipt of the report by the LDSS and shall be documented on the Notification to Law Enforcement from Child Protective Services form located in Appendix C. The form is also available on the public VDSS website under forms. The notification form shall be signed by the LDSS representative making

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[5] The Code of Virginia § 18.2-371 defines contributing to the delinquency of a minor as:

Any person 18 years of age or older, including the parent of any child, who (i) willfully contributes to, encourages, or causes any act, omission, or condition which renders a child delinquent, in need of services, in need of supervision, or abused or neglected as defined in §16.1-228, or (ii) engages in consensual sexual intercourse or anal intercourse with or performs cunnilingus, fellatio, or anilingus upon or by a child 15 or older not his spouse, child, or grandchild, is guilty of a Class 1 misdemeanor. This section shall not be construed as repealing, modifying, or in any way affecting §§ 18.2-18, 18.2-19, 18.2-61, 18.2-63, and 18.2-347.

the notification and the law enforcement agency representative receiving the notification. The form and signatures may be completed electronically or in writing.

The Notification to Law Enforcement form has been updated to include complaints and reports involving unrelated violent sexual offenders left alone with a child. See Section 3.6.3.

3.6.3 Report complaints involving *Tier III* sexual offenders

> (§63.2-1503 D). The local department shall notify the local attorney for the Commonwealth of all complaints of suspected child abuse or neglect involving the child's being left alone in the same dwelling with a person to whom the child is not related by blood or marriage and who has been convicted of an offense against a minor for which registration is required as a *Tier III* sexual offender pursuant to § 9.1-902, immediately, but in no case more than two hours of receipt of the complaint, and shall provide the attorney for the Commonwealth with records and information of the local department that would help determine whether a violation of post-release conditions, probation, parole, or court order has occurred due to the nonrelative sexual offender's contact with the child.

All complaints or reports involving a child being left alone in the same dwelling with a *Tier III* sexual offender who is not related to the child by blood or marriage must be reported to local attorney for the Commonwealth **immediately but not more than two (2) hours** of receipt of the complaint or report.

The LDSS shall provide records and information to the local attorney for the Commonwealth that would help determine whether a violation of post-release conditions, probation, parole, or court order has occurred due to the nonrelative sexual offender's contact with the child.

The LDSS must document the date and time of notification to the local attorney for the Commonwealth in the child welfare information system. This notification should be documented on the referral acceptance screen and in the referral as an Interview and Interaction (I and I). The LDSS may use the Notification to Law Enforcement form which has been updated to include complaints and reports involving violent sexual

offenders. The form is located in Appendix C and is also available on the public VDSS website under forms.

3.6.4 Memoranda of understanding with law enforcement and Commonwealth's attorney

The Code of Virginia § 63.2-1503 J and the Virginia Administrative Code state:

> (22 VAC 40-705-50 E) Pursuant to § 63.2-1503 D of the Code of Virginia, the local department shall develop, where practical, a memoranda of understanding for responding to reports of child abuse and neglect with local law enforcement and the local office of the commonwealth's attorney.

Since many situations are required to be reported to local law enforcement and/or the attorney for the Commonwealth, children and families will be better served if there is an understanding between these organizations and the LDSS. It is recommended that these agencies develop a written agreement regarding how varied situations will be handled, how communications should flow, etc. Provisions for roles and responsibilities of all parties, cross-training of staff, updating the agreement, and resolving problems are other examples of what the agreement should include in order for it to be an effective and continuous agreement among these agencies that are so vital to the protection of children.

3.6.5 Report military dependents to Family Advocacy Program

Effective July 1, 2017, all reports involving a dependent child of an active duty military member or a member of his household shall be reported to the Military Family Advocacy Program. This includes invalid complaints or reports.

> (§ 63.2-1503 N of the Code of Virginia) Notwithstanding any other provision of law, the local department, in accordance with Board regulations, shall transmit information regarding reports, complaints, family assessments, and investigations involving children of active duty members of the United States Armed Forces or members of their household to family advocacy representatives of the United States Armed Forces.

Once a report has been determined invalid and it involves a dependent child, the LDSS shall report the information to the Family Advocacy Program. This notification

can be made either verbally or in writing and must be documented on the referral acceptance screen in the child welfare information system. This notification should include whether or not the military member is aware that the report has been made to CPS. If the report is valid, notification shall occur once the response is complete. See Section 4.4.18.4 for notifications in a family assessment and Section 4.5.34.9 regarding investigations.

For additional information about the Family Advocacy Program, contact information for a particular branch of the military or a specific installation, click here.

3.7 Report Child Fatalities and Near *Fatalities*

3.7.1 Report a child fatality

> (22 VAC 40-705-50 F). The local department shall report to the following when the death of a child is involved:
> 1. When abuse or neglect is suspected in any case involving the death of a child, the local department shall report the case immediately to the regional medical examiner and the local law enforcement officer pursuant to § 63.2-1503 E of the Code of Virginia.
> 2. When abuse or neglect is suspected in any case involving the death of a child, the local department shall report the case immediately to the attorney for the Commonwealth and the local law enforcement agency pursuant to § 63.2-1503 D of the Code of Virginia.
> 3. The local department shall contact the department immediately upon receiving a complaint involving the death of a child and at the conclusion of the investigation.

The VAC requires the LDSS to immediately contact the Regional Medical Examiner, attorney for the Commonwealth, local law enforcement, and the CPS Regional Consultant when a report or complaint alleging abuse or neglect involves the death of a child.

The LDSS must document the notifications in the child welfare information system.

See Section 11, Child Deaths, of this guidance manual for additional requirements and guidance related to a report of a child death due to suspected abuse or neglect.

3.7.1.1 Examples of a child fatality

The U.S. Department of Justice indicates the majority of child fatalities can be categorized as the result of either acute or chronic maltreatment.

Acute maltreatment means the child's death is directly related to injuries suffered as a result of a specific incident of abuse or act of negligence. Often times, in cases of acute maltreatment the child has not been previously abused or neglected. Some examples of an acute maltreatment child fatality include:

- A child accesses an unsecured, loaded handgun in the home and fatally shoots himself.
- A young child is playing outside with siblings near the family pool. The caregiver briefly goes inside and when they return the young child is found unresponsive in the pool.
- A child is fatally thrown from a vehicle in a motor vehicle crash. It is determined the child was not restrained at the time of the accident.

Chronic maltreatment means the child's death is directly related to harm caused by abuse or neglect occurring over a period of time. Some examples of a chronic maltreatment child fatality include:

- A child receives fatal physical injuries and is diagnosed with Battered Child Syndrome/Chronic Physical Abuse. See Section 2.8 Appendix A: Battered Child Syndrome for more information on Battered Child Syndrome.
- A young child does not receive enough nutrition to sustain normal growth and development and is diagnosed with Nonorganic Failure to Thrive. See Section 2.9 Appendix B: Failure to thrive syndrome for more information on Failure to Thrive Syndrome.
- A child with a life-threatening medical condition does not receive necessary medical care or have access to life-sustaining medications. See Section 2.5.3.2 Parent refuses treatment for life-threatening condition

and Section 2.5.4 Child under alternative treatment for information on additional factors to consider when evaluating for medical neglect.

3.7.2 Report "near fatality" of a child

The Child Abuse and Prevention Treatment Act (CAPTA) defines a "near fatality" as an act that, as certified by a physician, places the child in serious or critical condition. The VAC provides the following definitions:

> (22VAC40-705-10) "Near fatality" means an act that, as certified by a physician, places the child in serious or critical condition. Serious or critical condition is a life-threatening condition or injury.
>
> (22VAC40-705-10) "Life-threatening condition" means a condition that if left untreated more likely than not will result in death and for which the recommended medical treatments carry a probable chance of impairing the health of the individual or a risk of terminating the life of the individual.

Inherent within the definition of a near fatality is the requirement that a physician certify that the child is in serious or critical condition at the time of the report. Certification by a physician can be either in writing or verbal. Hospital records which indicate the child's condition is serious or critical and life threatening are sufficient. The physician certification must be documented in the child welfare information system.

Some questions the LDSS can ask the physician to help determine if the child's condition is a near fatality include, but are not limited to:

- Are the child's vital signs unstable?
- Is the child ill or unconscious?
- Is the outcome questionable or unfavorable?
- Does the child require hospitalization in an intensive care unit?
- Does the child require significant intervention in terms of airway management, ventilatory support and fluid, or medication resuscitation?

3.7.2.1 Examples of a near fatality of a child

Some examples of a near fatality by type of abuse or neglect include:

- **Physical Abuse**: A child has been diagnosed with Abusive Head Trauma and has been admitted to the Intensive Care Unit of the hospital. The attending physician has indicated the child's prognosis is poor and the child is in critical condition.

- **Physical Neglect**: A child overdoses on the caretaker's psychotropic medication that had not been stored properly. The child is in a coma and the doctor reports the child may die.

- **Physical Neglect (FTT)**: A child is admitted to the pediatric intensive care unit due to significant weight loss and possible malnutrition. The doctor has diagnosed the child as non-organic Failure to Thrive and states the child is seriously ill.

- **Medical Neglect**: A child with diabetes is admitted to the hospital due to medical complications directly related to the caretakers not following the prescribed medical treatment (giving the child their insulin). The hospital records indicate the child presented in a life threatening condition.

Child maltreatment deaths may involve a delay between the time the child is determined to be in critical or serious condition and the subsequent death of the child.

3.7.2.2 Notification and documentation of near fatalities

The LDSS must inform the CPS Regional Consultant as soon as possible of all situations which constitute a near fatality and document the notification in the child welfare information system.

The LDSS must document situations which constitute a near fatality of a child in the child welfare information system in conjunction with the type of abuse or neglect that is alleged to have caused the near fatality.

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If during the course of the investigation the child dies, the child welfare information system must be changed to reflect the fatality. A child cannot be considered a near fatality and a fatality.

Additional guidance on disclosing near fatality information and findings can be located in Section 11, Child Deaths, of this guidance manual.

3.8 Screen valid complaints and reports for priority

The LDSS must consider and analyze all the information collected at the time of the referral to determine the most appropriate response to initiate a family assessment or investigation based on the child's immediate safety or other factors.

Response time is defined in the VAC:

> (22VAC40-705-10) "Response time" means a reasonable time for the local department to initiate a valid report of suspected child abuse or neglect based upon the facts and circumstances presented at the time the complaint or report is received.

The LDSS determines urgency of response time for valid reports by completing the response priority decision trees in the CPS Intake Tool documented in the child welfare information system. The response priority decision trees are designed to assist in determining how quickly to initiate the response. Selections made on the response priority decision trees must relate to supporting narrative in the child welfare information system.

Timeliness of the initial response is calculated from the date and time of the referral. There are three (3) response levels:

Response 1 (R1): as soon as possible **within 24 hours** of the date and time of the referral

Response 2 (R2): as soon as possible **within 48 hours** of the date and time of the referral

Response 3 (R3): as soon as possible **within *40 work hours*** of the date and time of the referral

For example, if a valid report is received on Monday at 10:20 am, the timeliness of the initial response would be calculated as follows based on the three response levels:

Response 1 (R1): as soon as possible but no later than Tuesday at 10:20 am

Response 2 (R2): as soon as possible but no later than Wednesday at 10:20 am

Response 3 (R3): as soon as possible but no later than the following Monday at 10:20 am

All decisions to override the response level must be approved by the supervisor and documented in the child welfare information system. Copies of the CPS Intake Tool and definitions are located on the forms webpage on the DSS public website. Since determining urgency of response is critical for valid reports, the following guidance is provided:

> (22 VAC 40-705-50 G): Valid complaints or reports shall be screened for high priority based on the following:
>
> 1. The immediate danger to the child;
>
> 2. The severity of the type of abuse or neglect alleged;
>
> 3. The age of the child;
>
> 4. The circumstances surrounding the alleged abuse or neglect;
>
> 5. The physical and mental condition of the child; and
>
> 6. Reports made by mandated reporters.

3.8.1 The immediate danger to the child

The following information should be gathered, when possible, and should be evaluated in addition to the specifics of the complaint:

- Is the child in current distress, injured, or otherwise in an unsafe environment?

- What plans do the caretakers have for the future or continued protection of the child?
- Has the abuse or neglect diminished or stopped, or is the child thought to be at risk of continued abuse or neglect?
- Is the living situation immediately dangerous?
- Is any child currently left unsupervised who is age 8 or under or too disabled to care for self?
- Is the caretaker not available and no provision made for child's care?
- Is law enforcement requesting immediate response?
- Will perpetrator have access to child in next 48 hours?
- Are severe parental or caretaker substance abuse, developmental disabilities, or mental illness issues present AND no other appropriate caretaker is present?
- Does child's behavior put self at risk and caretaker does not respond appropriately?
- Is the child in an alternative safe environment?
- Has a substantial amount of time passed since the incident occurred?

3.8.2 The severity of the type of abuse or neglect alleged

The following information should be gathered, when possible, and should be evaluated in addition to the specifics of the complaint:

- Are there allegations or evidence of broken bones, fractures, cuts, broken skin, severe bruising, or serious maltreatment?
- Were instruments or other items, such as guns, knives, or belts, used in the infliction of the abuse or neglect?

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- Is the neglect or abuse of a continuing or chronic nature? Is there evidence establishing a pattern of abusive or neglectful behavior?
- Is the threat of abuse or neglect imminent?
- Can the caretaker be located? Is the caretaker not available?
- Is it likely that the precipitating event or one similar will reoccur?
- Are factors in the environment (both in and outside the home) observed to have an impact on the actual or threat of harm to the child?
- Were severe or bizarre disciplinary measures used, or was abuse premeditated?
- Is medical care required; or are significant bruises, contusions, or burns evident?
- Is caretaker's behavior toward child extreme, severe, or bizarre?

3.8.3 The age or vulnerability of the child

The following information should be gathered, when possible, and should be evaluated in addition to the specifics of the complaint:

- Does the child's age, sex, developmental level, chronological age, or maturation level effect the child's vulnerability to abuse or neglect?
- What is the child's capacity to protect him or herself from future abuse or neglect?
- Is the child able to express thoughts or responses regarding the allegation of abuse or neglect?
- Is the child currently alone with, or repeatedly left alone with, a non-related violent sex offender?

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- Does information show observable and substantial impairment in child's ability to function in a developmentally appropriate manner?

3.8.4 The circumstances surrounding the alleged abuse or neglect

The following information should be gathered, when possible, and should be evaluated in addition to the specifics of the complaint:

- Who is responsible for the abuse or neglect?
- What is being reported?
- When did the abuse or neglect occur?
- Where did the abuse or neglect occur?
- Were other individuals aware or witness to the circumstances of the abuse or neglect?
- Are siblings of the victim child aware or witness to the abuse or neglect?
- Did the abuse or neglect occur during a punishment or instructional contact with the child?
- What is the likelihood that the circumstances leading to the abuse or neglect will reoccur?
- Is the allegation exposure to drug-related activity and/or involves a meth lab?
- Is the family about to flee or have a history of fleeing?
- Is non-involved caretaker's response appropriate and protective of child?
- Is non-involved caretaker unaware of abuse or is the response to abuse unknown?
- Does perpetrator have access, or is child afraid to go home?

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3.8.5 The physical and mental condition of the child

The following information should be gathered, when possible, and should be evaluated in addition to the specifics of the complaint:

- Is the child thought to be of normal development and possess the ability to communicate during the investigation?
- Are there known illnesses, developmental delays, or other impediments to normal growth and development of the victim child?
- Does the child's perception of his role impact his or her vulnerability for abuse or neglect?
- Does child appear seriously ill or injured and in need of immediate medical care?
- Is any child age eight (8) or under or limited by disability?

3.8.6 Complaints made by mandated reporters

The following information should be gathered, when possible, and should be evaluated in addition to the specifics of the complaint:

- When was the mandated reporter made aware of the circumstances involving the alleged abuse or neglect?
- In what capacity did the mandated reporter know the alleged victim child? What was the relationship between the alleged victim child and the mandated reporter?
- Has the mandated reporter discussed the circumstances with the child? With the parents? Other professionals?
- Does the mandated reporter possess other relevant information such as knowledge about the living conditions or other environmental factors?

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- What actions or services are recommended by the mandated reporter?

3.8.7 Initiating a response to a valid report

Timeliness of the initial response is calculated from the date and time when the referral is received. The initial response is the first completed contact with the alleged victim. The LDSS shall conduct a face-to-face interview with and observe the alleged victim child **within the initial response priority level assigned**, as this contact is critical to assessing the safety of the child and is the required federal measure. Sometimes the LDSS's initial efforts to respond to the report will not be successful such as when no one is home; however, the LDSS must use reasonable diligence to locate the alleged victim within the determined response priority. For more guidance on reasonable diligence, refer to Section 4: Assessments and Investigations of this manual.

To ensure the face-to face contact with the alleged victim is completed within the required response priority, the supervisor must establish the date and time of the supervisory consultation at the time of referral assignment. The supervisory consultation must occur in advance of the expiration of the response priority to ensure the contact is completed within the mandated time frame. The consultation must include a discussion of the Family Services Specialist's reasonable diligence documented in the child welfare information system and a solution to ensure a face-to-face contact is completed with the alleged victim within the response priority. The supervisory consultation must be documented in the child welfare information system.

All contacts, attempted or completed, in the family assessment and investigation must be entered into the child welfare information system to document the LDSS's response to the report and to document compliance with CPS program requirements. This includes documentation of all attempted contacts as well as case planning that affect the initiation of the family assessment or investigation; however, only completed face-to-face contacts with the alleged victim satisfy the timeliness of initial response measure.

The VAC further addresses response time:

> (22VAC40-705-50 H) The local department shall respond within the determined response time.

(22VAC40-705-80 A1) The child protective services worker shall conduct a face-to-face interview with and observe the alleged victim child within the determined response time.

Initial response may or may not be the same as first meaningful contact. See Section 4, Family Assessment and Investigation, of this guidance manual for further guidance on first meaningful contact and initial safety assessment.

The LDSS may not respond to a complaint or report of child abuse or neglect to determine the validity of the referral. The validity determination must be made prior to the response of the LDSS. Once the LDSS responds to a complaint or report of child abuse or neglect, the LDSS is responsible for ensuring the completion of a family assessment or investigation.

3.8.8 Response time for child less than two years of age

Effective July 1, 2017, all valid reports that involve a child victim less than two years of age must receive an R1 response (**within 24 hours**).

3.9 Determine the appropriate response: family assessment or investigation

The Code of Virginia § 63.2-1503 I authorizes the LDSS to determine validity of a complaint or report. For all valid complaints or reports, the LDSS shall determine whether to conduct a family assessment or an investigation.

After the decisions regarding validity and urgency, a decision must be made as to whether to conduct a family assessment or an investigation. Certain complaints or reports are required by the Code of Virginia to be investigated.

Effective July 1, 2017, all valid substance exposed infant (SEI) reports shall receive a family assessment unless an investigation is required by law or necessary to protect the safety of the child. See Section 10: Substance Exposed Infants for new requirements and guidance when responding to SEI reports.

Effective July 1, 2018, all valid complaints or reports involving a child's being left alone in the same dwelling with a person to whom the child is not related by blood or marriage

and who has been convicted of an offense against a minor which registration is required as violent sexual offender shall receive an investigation. The family assessment track is no longer permitted for these valid complaints or reports.

> (*§ 63.2-1506 C* of the Code of Virginia) When a local department has been designated as a child-protective services differential response agency by the Department, the local department may investigate any report of child abuse or neglect, but the following valid reports of child abuse or neglect shall be investigated: (i) sexual abuse, (ii) child fatality, (iii) abuse or neglect resulting in serious injury as defined in § 18.2-371.1, (iv) cases involving a child's being left alone in the same dwelling with a person to whom the child is not related by blood or marriage and who has been convicted of an offense against a minor for which registration is required as a violent sexual offender pursuant to § 9.1-902, (v) child has been taken into the custody of the local department, or (vi) cases involving a caretaker at a state-licensed child day center, religiously exempt child day center, licensed, registered or approved family day home, private or public school, hospital or any institution. If a report or complaint is based upon one of the factors specified in subsection B of § 63.2-1509, the local department shall (a) conduct a family assessment, unless an investigation is required pursuant to this subsection or other provision of law or is necessary to protect the safety of the child, and (b) develop a plan of safe care in accordance with federal law, regardless of whether the local department makes a finding of abuse or neglect.
>
> (§ 18.2-371.1 A of the Code of Virginia) Any parent, guardian, or other person responsible for the care of a child under the age of 18 who by willful act or omission or refusal to provide any necessary care for the child's health causes or permits serious injury to the life or health of such child shall be guilty of a Class 4 felony. For purposes of this subsection, "serious injury" shall include but not be limited to (i) disfigurement, (ii) a fracture, (iii) a severe burn or laceration, (iv) mutilation, (v) maiming, (vi) forced ingestion of dangerous substances, or (vii) life-threatening internal injuries.

3.9.1 Make the response track decision

Family assessments are conducted when the concerns outlined in the report indicate inadequate parenting or life management rather than dangerous parenting practices and actions. The VAC defines family assessment as follows:

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> (22 VAC 40-705-10). “Family assessment” means the collection of information necessary to determine:
> 1. The immediate safety needs of the child;
> 2. The protective and rehabilitative services needs of the child and family that will deter abuse or neglect;
> 3 Risk of future harm to the child; and
> 4. Alternative plans for the child’s safety if protective and rehabilitative services are indicated and the family is unable or unwilling to participate in services. These arrangements may be made in consultation with the caretaker(s) of the child.

An investigation is conducted when the allegations in the report are required by statute or indicates there is serious abuse or neglect resulting in immediate or impending harm to the child. The VAC defines an investigation as follows:

> (22 VAC 40-705-10).
> "Investigation" means the collection of information to determine:
> 1. The immediate safety needs of the child;
> 2. The protective and rehabilitative services needs of the child and family that will deter abuse or neglect;
> 3. Risk of future harm to the child;
> 4. Alternative plans for the child’s safety if protective and rehabilitative services are indicated and the family is unable or unwilling to participate in services;
> 5. Whether or not abuse or neglect has occurred;
> 6. If abuse or neglect has occurred, who abused or neglected the child; and
> 7. A finding of either founded or unfounded based on the facts collected during the investigation.

The immediate danger to the child and the severity of the alleged abuse or neglect are crucial factors to be considered. This guidance is not intended to be all inclusive and does not replace the LDSS judgment regarding alleged safety threats and risk factors.

The LDSS completes the differential response decision on the CPS Intake Tool in the child welfare information system. This checklist and the definitions assist with consideration of statutory mandates for the investigation track and other serious

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situations which may be appropriate for the investigation track. The CPS Intake Tool is located on the DSS public website.

Additional guidance regarding track decisions when DV is involved can be found in section 1.4.4.2 of the VDSS Child and Family Services Manual, Chapter H, Domestic Violence.

The following variables should be considered when determining the track. The LDSS should assign a report to the investigation track if one or more of the following variables are present:

- If there is a **third** valid CPS report within 12 months, it must be investigated.
- Type and severity of alleged abuse. Serious injuries as defined in § 18.2-371.1 are required by the Code of Virginia to be investigated. Those injuries include but are not limited to disfigurement, bone fractures, severe burns or lacerations, mutilation, maiming, forced ingestion of dangerous substances, and life-threatening internal injuries. A serious injury also includes brain damage, subdural hemorrhage or hematoma, dislocations, sprains, scalds or any other physical injury that seriously impairs the health or well-being of the child and requires medical treatment (e.g., suffocating, shooting, significant bruises/welts, bite marks, choke marks).Non-organic failure to thrive of an infant.
- Use of excessive physical discipline or physical force. This includes using torture or excessive physical force, or acting in a way that bears little resemblance to reasonable discipline given the child's age and stage of development; or caretaker punished child beyond the duration of the child's endurance. (e.g., punching child in head or stomach, tying child up, locking child in a closet, slamming child against wall, or punishing child in a way that produces humiliation or degradation, punishing child for acts that are outside child's control).
- History of abuse or neglect. Consider previous maltreatment by a caretaker that was serious enough to have caused a severe injury. Take into consideration if

parental rights have been terminated on any other children as a result of prior child maltreatment.

- Caretaker failed to benefit from previous professional help. Consider if the caretaker previously maltreated a child in their care and was referred for services, but did not participate in or did not benefit from those services.

- Child's age and ability to self-protect. The age of the child is a critical factor since any abuse or neglect to a child six (6) years of age and under has the potential to constitute a serious and immediate safety threat to the child's health and safety. Consider the presence of a disability that affects the child's ability to self-protect regardless of age.

- Threaten to cause harm or retaliate against the child. Consider if there is a threatening action that would result in serious harm or a household member plans to retaliate against the child for CPS involvement. Consider whether or not the caretaker's behavior is violent or out of control.

- Living conditions. Child's physical living conditions are reported to be hazardous and immediately threatening, based on the child's age and developmental status. This includes reports indicating illegal drugs are being sold or manufactured in the home and unsecured weapons.

- Child's proximity to DV incident. Consider if the child was in immediate danger of serious physical harm by being in close proximity to an incident(s) of assaultive behavior/DV between adults in the household.

- If there is reason to believe that a child's safety will be jeopardized if parental cooperation cannot be obtained prior to interviewing the child.

If the allegations are not required by statute to be investigated or do not include any of the above variables, the report may be placed in the family assessment track.

The track decision should be made at intake, before responding, if at all possible.

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If sufficient information cannot be obtained from the complainant, the track assignment can be made at the point of the first meaningful contact with any parties named in the complaint. Additional local criteria for track assignment may be developed, but the criteria must be consistently applied within the locality. The chart that follows is intended to assist local CPS staff in evaluating child abuse and neglect reports for placement in a response track.

The LDSS may not respond to a complaint or report of child abuse or neglect to determine the validity of the referral. The validity determination must be made prior to the response of the LDSS. Once the LDSS responds to a complaint or report of child abuse or neglect, the LDSS is responsible for ensuring the completion of a family assessment or investigation.

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3.9.2 CPS Report Placement Chart

FAMILY ASSESSMENT RESPONSE	INVESTIGATION RESPONSE
Mandated by Code of Virginia (§ 63.2-1506 C): - **Substance Exposed Infant** reports shall be handled as a Family Assessment.	**Mandated by Code of Virginia (§ 63.2-1506 C):** - All sexual abuse allegations - Any child fatality - Abuse or neglect resulting in serious injury as defined in § 18.2-371.1 * [also consider medical neglect of disabled infant with life threatening condition (Baby Doe)]; - Child taken into agency custody due to abuse or neglect (§ 63.2-1517) - Child taken into protective custody by physician or law enforcement, pursuant to § 63.2-1517 - All allegations regarding a caretaker in a designated out of family setting as defined in § 63.2-1506 C - Child's being left alone in the same dwelling with a person to whom the child is not related by blood or marriage and who has been convicted of an offense against a minor for which registration is required as a *Tier III* sexual offender pursuant to §9.1-902
Policy mandate: After a family has received two (2) valid CPS reports within 12 months, the **third** report must be investigated.	**Policy mandate:** All allegations regarding a caretaker in an out of family setting of any kind, i.e. foster homes, day care, residential facilities.
Examples of when this response may be most appropriate: **Physical Abuse:** Abusive treatment of a child that may or may not have caused a minor injury – no medical treatment required.	Examples of when this response is **most appropriate**, but not mandated by law: **Physical Abuse**: Physical abuse that causes or threatens to cause serious injury (other than that defined in § 18.2-371.1*);

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Mental Abuse: Child is experiencing minor distress or impairment; child's emotional needs are sporadically met but there are behavioral indicators of negative impact. Child exposed to DV. **Neglect:** Lack of supervision where child is not in danger at time of report; minor injuries suggesting inattention to child safety.	or that may require medical evaluation, treatment or hospitalization. Reports of children present during the sale or manufacture of illegal substances; and highly recommend these be investigated jointly with law enforcement. **Mental Abuse**: Child is experiencing serious distress or impairment; child's emotional needs allegedly are not being met or are severely threatened. **Neglect:** Lack of supervision that causes or may cause serious injury or illness; injury or threat of injury due to use of weapons in the home. **Non-Organic Failure to Thrive:** Child is an infant and at imminent risk of severe harm. **Child Abandonment** referrals. **Third valid CPS report in 12 months**

* Note that § 18.2-371.1 A includes, but is not limited to, disfigurement, fracture, severe burns or lacerations, mutilation, maiming, forced ingestion of dangerous substances, or life threatening internal injuries.

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3.10 Appendix A: Children home alone

Virginia state statutes do not set a specific age after which a child legally can stay alone.* Age alone is not a very good indicator of a child's maturity level. Some very mature 10-year-olds may be ready for self-care while some 15-year-olds may not be ready due to emotional problems or behavioral difficulties. In determining whether a child is capable of being left alone and whether a parent is providing adequate supervision in latchkey situations, CPS will assess several areas. These areas include:

- **Child's level of maturity**. CPS will want to assess whether the child **is physically capable** of taking care of himself; **is mentally capable** of recognizing and avoiding danger and making sound decisions; **is emotionally ready** to be alone; knows what to do and whom to call if an emergency arises; and has special physical, emotional, or behavioral problems that make it unwise to be left alone. **It is important to note that a child who can take care of him/herself may not be ready to care for younger children.**

- **Accessibility of those responsible for the child**. CPS will want to determine the location and proximity of the parents, whether they can be reached by phone and can get home quickly if needed, and whether the child knows the parents' location and how to reach them.

- **The situation**. CPS will want to assess the time of day and length of time the children are left alone; the safety of the home or neighborhood; whether the parents have arranged for nearby adults to be available in case a problem arises; and whether there is a family history of child abuse or neglect.

* Some localities have ordinances concerning the age at which a child may be left without supervision.

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3.11 Appendix B: Distinguishing between accidental and non-accidental injury

One of the most critical responsibilities of child welfare staff during the investigation or review of a child's death is to distinguish between accidental and non-accidental injuries. This is particularly difficult when staff must distinguish between accidents in which chronic neglect or inadequate supervision was a factor and those where neglect is not a concern. In most cases, medical input will be required to make such a determination. These situations include those where the conditions resulting in the child's death appear to be directly created by or under the control of the parent or other person responsible for the child's care, yet the death is not identified as relating to a specific type of maltreatment, as well as those deaths that are alleged or known to have occurred as a result of abuse or neglect. Consideration of the following four (4) factors can provide guidance for this process:

- **Discrepant history**. In some cases, the nature of the injury does not match the history given by the parent or other person responsible for the child's care. To determine this requires a detailed description of the incident. What were the circumstances leading up to and following the incident? When did it occur? Who was present at the time of the incident? What were the specific medical assessment of how the injuries occurred and the detailed description of the injuries and the child's condition? What information was obtained during the onsite visit?

- **Delay in seeking medical care**. At times, the delay in seeking medical care can range from a few moments to hours. In assessing delay, it is important to realize, for example, that following a severe shaking or beating, the abuser will often place a child down in a crib or on the floor and leave the room. The child may then exhibit symptoms of intracranial pressure (vomiting, seizures, and cardio respiratory arrest). These symptoms then cause the person responsible for the abuse to contact emergency help, and that person often disassociates the symptoms from their previous actions.

- **Triggering event by the child(ren)**. This is usually age-specific behavior, such as inconsolable crying, a messy diaper, toilet training problems, etc., which triggers the abuse.

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- **A crisis in the family**. A crisis may have placed additional stress on the family's capacity to cope. Crisis can take the form of unexpected or difficult pregnancy, marital differences, loss of job, or death of an extended family member.

3.12 Appendix C: Notification to Law Enforcement from Child Protective Services

This notification is being made due to a report of suspected child abuse or neglect that alleges one or more of the following* (check all that apply):

	Death of a child
	A felony or Class 1 misdemeanor injury or threatened injury to a child
	Sexual abuse, suspected sexual abuse or other sexual offense involving a child, including but not limited to the use or display of a child in sexually explicit visual material, as defined in § 18.2-374.1
	Abduction of a child
	Felony or Class 1 misdemeanor drug offense involving a child
	Contributing to the delinquency of a minor in violation of § 18.2-371
	Child left alone in the same dwelling with an unrelated registered *Tier III* sexual offender

* Refer to Section 3.6 of the CPS Policy/ Guidance Manual for additional information

Name (s) of victim children involved	Name (s) of alleged perpetrators (if known)

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	Initial Notification to law enforcement		
OASIS Referral #	Date:		Time:
Name of LDSS representative	Date	Time	Signature (may be electronic)
Name of local law enforcement officer	Date	Time	Signature (may be electronic)

This form documents notification to local law enforcement pursuant to § 63.2-1503 of the Code of Virginia. This document shall be completed and signed by all parties within two business days of receipt of CPS report. A copy of this form shall be included in the CPS record. This form may be completed in writing or electronically.

This form may also be used pursuant to §63.2-1503 of the Code of Virginia to notify the local attorney for the Commonwealth of reports involving a child left alone in the same dwelling with a registered violent sexual offender, within 2 hours of the receipt of the complaint.

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OUT-OF-FAMILY INVESTIGATIONS

TABLE OF CONTENTS

DRAFT

DRAFT

DRAFT

DRAFT

DRAFT

5

5.1 Introduction

If a CPS report involves *the abuse or neglect of a child in an out-of-family setting*, that investigation is deemed an "out-of-family" (OOF) investigation. There are many types of settings and situations that are considered OOF settings. These settings include those regulated by other agencies such as state licensed and religiously exempted child day care centers, regulated family day homes, private and public schools, locally approved foster homes, child placing agencies, group residential facilities, hospitals, or institutions. OOF settings may also include settings that are not externally regulated such as camps, athletic leagues, children's clubs, babysitters who are not required to be regulated, babysitting co-ops, and "sleepovers" at friends' homes. Depending on the setting, there are certain regulations and policies that apply to the conduct of these CPS investigations.

This section sets forth the requirements and guidance for responding to child abuse and neglect reports in OOF settings. Complaints of abuse and neglect in OOF settings differ from complaints in the child's family setting because:

- The alleged abuser(s) in OOF settings may be caring for the alleged victim(s) as part of their job duties.
- The outcome of the CPS investigation may have administrative, regulatory and/or personnel implications.
- CPS is mandated by Code of Virginia § 63.2-1506 C to respond to certain types of these valid allegations as Investigations (not Family Assessments).

There is a checklist of all requirements to conduct an OOF investigation in Appendix C: Checklist for OOF investigations.

5.2 Authorities

In addition to Virginia Administrative Code (VAC) 22 VAC 40-705 et. seq. that provides the regulatory authority for the general conduct of the CPS program, the VAC 22 VAC 40-730 et. seq. provides additional requirements for CPS to conduct OOF investigations in designated settings.

> (22VAC40-730-20). Complaints of child abuse or neglect involving caretakers in out of family settings are for the purpose of this (regulation) chapter complaints in state licensed and religiously exempted child day centers, regulated family day homes, private and public schools, group residential facilities, hospitals or institutions.
>
> These complaints shall be investigated by qualified staff employed by local departments of social services or welfare.
>
> Staff shall be determined to be qualified based on criteria identified by the department. All staff involved in investigating a complaint must be qualified.
>
> In addition to the authorities and the responsibilities specified in department policy for all child protective services investigations, the policy for investigations in out of family settings is set out in 22 VAC 40-730-30 through *22 VAC 40-730-140*.

All CPS authorities, procedures, and requirements applicable to in home investigations found in Section 4, Family Assessment and Investigation, apply to the investigation of complaints in an OOF setting. This section sets forth the additional requirements to respond to CPS reports in these OOF settings.

5.2.1 Minimum standards for CPS workers to conduct OOF investigations

> (22VAC40-730-130A). In order to be determined qualified to conduct investigations in out of family settings, local CPS workers shall meet minimum education standards established by the department including:
>
> 1. Documented competency in designated general knowledge and skills and specified out of family knowledge and skills; and
>
> 2. Completion of out of family policy training.

B. The department and each local department shall maintain a roster of personnel determined qualified to conduct these out of family investigations.

5.3 Definitions

In addition to the definitions contained in 22VAC40-705-10, 22 VAC 40-730-10 defines the following words and terms, when used in conjunction with this chapter, to have the following meanings, unless the context clearly indicates otherwise:

(22 VAC 40-730-10)
"Child Placing Agency" means those privately contracted agencies responsible for the training of specialized foster families and the intensive case management of the foster child.

"Child day program" means a regularly operating service arrangement for children where, during the absence of a parent or guardian, a person or organization has agreed to assume responsibility for the supervision, protection, and well-being of children as defined in §63.2-100 of the Code of Virginia.

"Facility" means the generic term used to describe the setting in out of family abuse or neglect and for the purposes of this regulation includes schools (public and private), private or state-operated hospitals or institutions, child day programs, state regulated family day homes, and residential facilities.

"Facility administrator" means the on-site individual responsible for the day-to-day operation of the facility.

"Participate" means to take part in the activities of the joint investigation as per a plan for investigation developed by the CPS worker with the facility administrator or regulatory authority or both.

"Physical plant" means the physical structure/premises of the facility.

"Regulatory authority" means the department or state board that is responsible under the Code of Virginia for the licensure or certification of a facility for children.

"Residential facility" means a publicly or privately owned facility, other than a private family home, where 24-hour care, maintenance, protection, and guidance is provided to children separated from their parents or legal guardians, that is subject to licensure or certification

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pursuant to the provisions of the Code of Virginia and includes, but is not limited to, group homes, secure facilities, temporary care facilities, and respite care facilities.

5.3.1 Additional definitions used in OOF investigations

The following definitions are also commonly used in the guidance and procedures to conduct OOF investigations:

Term	Definition
Hospitals and Institutions	The residential placement responsible for the care and treatment of a child for behavioral and/or psychological reasons. These include juvenile detention and residential treatment facilities.
Locally Approved	The process where a local agency has approved and prepared a family for placement of local foster children or a home for placement of daycare children

5.3.2 Child care definitions

The following definitions are from the Child Care and Licensing Divisions of VDSS. Additional information regarding child care and licensing can be found on the public website.

Term	Definition
Child Day Centers	These are child day programs offered to (i) two (2) or more children under the age of 13 years in a facility that is not the residence of the provider or any of the children in care, or (ii) 13 or more children at any location. Additional information can be found on the public website.

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Family Day Homes	These are homes that provide the care for five (5) to 12 children (exclusive of the provider's own children) and required by the Code of Virginia to be licensed. Additional information can be found on the public website. Note: Homes that provide care for four (4) or less children (exclusive of their own children) are not required to be licensed.
Family Day System Homes	The Code of Virginia requires licensure of any person who approves family day homes as a member of its system and who refers children to available day homes in that system. Additional information can be found on the public website. The only licensed Family Day Home System is operated by Infant/Toddler Family Day Care.
Religiously Exempt Day Care Center	A child day center may be exempt from licensing requirements and regular inspections due to its mission as a religious facility. Additional information can be found on the public website.
Voluntarily Registered Family Day Homes	These homes have fewer than five (5) children in care (exclusive of the provider's own children). Voluntary registration is a form of regulation offered to family day homes that are not required to be licensed. Additional information can be found on the public website.

5.4 Responsibilities to conduct OOF investigations

5.4.1 Determine validity of report or complaint in OOF settings

The criteria used to determine validity of an allegation in an OOF setting are the same as that in an allegation of an "in-home" setting. These criteria are discussed in Section 3, Complaints and Reports of this guidance manual. Additional criteria for reports involving school personnel can be located in Section 5.10.

The Code of Virginia § 63.2-1506 C requires CPS reports in certain OOF settings to be investigated. These settings include programs that are subject to state regulatory oversight and where the relationship between the alleged victim child and caretaker

is more professional than familial. In addition, CPS reports in locally approved provider settings must be investigated.

5.4.2 Identify the regulatory agency

- The *Virginia Department of Education (DOE)* licenses or certifies facilities such as child day centers, including religiously exempt child day centers, licensed and voluntarily registered family day homes, and certain child care institutions and group homes. Contact information for *DOE* Regional Licensing Offices is available on the public website.

- The Department of Juvenile Justice (DJJ) operates juvenile correctional centers and halfway houses throughout the state. For investigations involving state-operated facilities, contact the appropriate facility superintendent. Contact information for these facilities is available on the DJJ website. Also contact the DJJ Gang and Investigation Unit (804-588-3850) to report the child abuse/neglect allegations.

- DJJ also certifies locally-operated detention homes and group homes. For investigations involving locally-operated detention homes and group homes, contact the DJJ Serious Incident Report (SIR) 24-hour hotline at (804)-212-8803, or the Certification Manager at (804)-516-9491 to notify the appropriate Certification Analyst.

- The Department of Behavioral Health and Developmental Services (DBHDS) operates or licenses group homes; treatment facilities for children with substance abuse issues, developmental disabilities, and brain injuries; psychiatric hospitals that provide day or residential services to children; training centers; and state mental hospitals. Contact the DBHDS Office at (804)-786-1747 to reach the appropriate licensing specialist. Contact information is also available on the DBHDS website.

    - DBHDS has established an Office of Human Rights to assure and protect the legal and human rights of individuals receiving services in facilities or programs operated, licensed, or funded by DBHDS. This Office of Human Rights may serve as a resource to the LDSS during the course of some OOF investigations involving DBHDS licensed facilities. See Office of Human Rights Staff Directory for contact information.

- The Department of Education (DOE) licenses private schools for students with disabilities. This includes both day schools and schools within residential facilities. Contact Information and a listing of licensed private day and residential schools are available on the DOE website under Directory of Private Day and Residential Schools for Students with Disabilities. If a complaint of child abuse or neglect occurs in the school program of a residential facility or a private school for students with disabilities, contact DOE at (804)-371-0525 or ask the private school for the DOE specialist for their school and contact that person directly.

5.4.3 Facilities with no regulatory authority

> (22VAC40-730-50A). In a facility for which there is not a state regulatory authority, such as in schools, the CPS worker shall ask the facility administrator or school superintendent to designate a person to participate in the joint investigative process.

In an OOF investigation with no regulatory authority, the designated staff person participating in the investigation is not considered a co-investigator with the CPS worker. The CPS worker should review the investigative process and confidentiality requirements with the facility designee, whose function is to minimize duplication of investigation efforts by CPS and the facility. The CPS worker may exclude the designee from interviews as necessary.

5.4.4 Develop joint investigative plan

> (22VAC40-730-40.2). The CPS worker assigned to investigate and the appointed regulatory staff person will discuss their preliminary joint investigation plan.

The CPS worker and the appointed regulatory staff person shall confer on the preliminary investigation plan. The CPS worker and the regulatory staff person shall plan how each will be kept informed of the progress of the investigation and must confer at the conclusion of the investigation to inform the other of their respective findings and to discuss corrective action.

5.4.4.1 If regulatory staff is unavailable

If a designated regulatory staff person is not available to participate in the investigation process in a timely manner, the CPS worker should commence the investigation separately; however, efforts must be made to begin coordination and information-sharing as quickly as possible.

5.4.5 Notify CPS regional consultant

> (22VAC40-730-60B). The regional consultant shall be responsible for monitoring the investigative process and shall be kept informed of developments which substantially change the original case plan.

The CPS worker shall inform the CPS regional consultant of all OOF investigations as soon as possible. This may be done by sending an e-mail to the regional consultant that includes the following information:

- Referral # and locality.
- Type of abuse/neglect.
- Daycare/facility/school name.
- Brief case summary.

5.4.6 Notify Interstate Compact on the Placement of Children (ICPC)

If the alleged victim is in the custody of another state and has been placed in Virginia through ICPC, immediately notify the Virginia ICPC office and the state agency which has custody of the child. The CPS worker shall document this notification in the child welfare information system.

5.4.7 Time frames to complete investigations

The Code of Virginia requires the LDSS to complete and document the investigation within 45 calendar days of receipt of the complaint or report. There are three (3) exceptions for completing an investigation within 45 days.

5.4.7.1 Fifteen-day extension to complete investigation

> (22 VAC 40-705-120 A). The local department shall promptly notify the alleged abuser or neglector and the alleged victim's parents or guardians of any extension of the deadline for the completion of the family assessment or investigation pursuant to § 63.2-1505 B5 or § 63.2-1506 B3 of the Code of Virginia. The child protective services worker shall document the notifications and the reason for the need for additional time in the case record.

Upon written justification by the LDSS, based on locally determined guidelines, the investigation can be extended for **15 calendar days**.

5.4.7.2 Extension of joint investigations with law enforcement agency

The Code of Virginia, § 63.2-1505 (5) allows for investigations which are being conducted in cooperation with a local law enforcement agency to be extended an additional 45 days, not to exceed 90 days. This must be agreed upon by both the LDSS and the law enforcement agency. This extension applies only to investigations.

5.4.7.3 Notification of extension

If an investigation is extended, the alleged abuser/neglector shall be notified. The notification to the alleged abuser/neglector or involved caretakers should include a brief explanation of the reason for the extension. If written notification is made, a copy of the notification must be included in the LDSS's record. If notification is made verbally, then the LDSS must document the notification in the child welfare information system. The LDSS must document the justification in the child welfare information system for the additional time needed to complete the investigation.

Sample letters for notification of an extension of an investigation are located in this guidance manual, Section 4, Family Assessments and Investigations, Appendix K.

5.4.7.4 Suspension of certain investigations

> (22VAC40-705-120 B) Pursuant to § 63.2-1505 B5 of the Code of Virginia, when an investigation involving the death of a child or alleged sexual abuse of a child is delayed because of the unavailability of the records, the deadlines shall be suspended. When such unavailability of records occurs, the local department shall promptly notify the alleged abuser or neglector and the alleged victim's parents or guardians that the records are unavailable and the effect of the unavailability on the completion of the investigation. The child protective services worker shall document the notifications and the reason for the suspension in the case record. Upon receipt of the records necessary to make a finding, the local department shall complete the investigation.

The Code of Virginia § 63.2-1505 B5 grants exceptions to completing certain investigations under specific conditions. In any child death investigation or sexual abuse investigations which require reports or records generated outside the local department in order to complete the investigation, the time needed to obtain these reports or records shall not be counted towards the 45 days. These records must be necessary to complete the investigation and not available due to circumstances beyond the control of the local department. When the LDSS receives the reports or records, the 45 day timeframe resumes where it had left off, it does not start over.

The decision to suspend making a disposition within 45 days in these cases should be approved by a supervisor and documented in the child welfare information system.

5.4.7.5 Notification of suspension

The LDSS should notify the alleged abuser/neglector or involved caretakers and the alleged victim's parents or guardians when suspending an investigation. The notification to the alleged abuser/neglector or involved caretakers should include a brief explanation of the reason for the suspension. If written notification is made, a copy of the notification must be included in the LDSS's record. If notification is made verbally, then the LDSS must document the notification in the child welfare information system. The LDSS must document the justification in the child welfare information system for the additional time needed to complete the investigation.

5.4.7.6 Contact while investigation is suspended

As long as the investigation remains open, the LDSS retains all authorities and responsibilities of an investigation. The LDSS should document monthly updates in the child welfare information system until such time that the necessary reports or records to complete the investigation have been received.

5.5 Conduct OOF investigation

5.5.1 Joint interviews and information sharing

> (22VAC40-730-40.2a). The CPS worker and the regulatory staff person shall review their respective needs for information and plan the investigation based on when these needs coincide and can be met with joint interviews or with information sharing.

The LDSS shall share the complaint information with the regulatory authority who may appoint a staff person to participate in the investigation. The CPS worker and regulatory staff person should discuss informational needs, the feasibility of joint interviews, and develop an investigative plan.

5.5.2 Joint investigation requirements for LDSS and regulatory authority

(22VAC40-730-40.2b). The investigation plan must keep in focus the policy requirements to be met by each party as well as the impact the investigation will have on the facility's staff, the victim child or children, and the other children at the facility.

5.5.3 Joint investigation with law enforcement and facility

(22VAC40-730-50B). When CPS and law enforcement will be conducting a joint investigation, the CPS worker shall attempt to facilitate a coordinated approach among CPS, law enforcement and the regulatory authority or facility designee.

5.5.4 Notify facility administrator

(22VAC40-730-70A). The CPS worker shall initiate contact with the facility administrator or designee at the onset of the investigation.

B. The CPS worker shall inform the facility administrator or his designee of the details of the valid complaint. When the administrator or designee chooses to participate in the joint investigation, he will be invited to participate in the plan for investigation, including decisions about who is to be present in the interviews. If the administrator or designee is the alleged abuser or neglector, this contact should be initiated with the individual's superior, which may be the board of directors, etc. If there is no superior, the CPS worker may use discretion in sharing information with the administrator.

C. Arrangements are to be made for:

1. Necessary interviews;

2. Observations including the physical plant; and

3. Access to information, including review of pertinent policies and procedures.

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> D. The CPS worker shall keep the facility administrator or designee apprised of the progress of the investigation. In a joint investigation with a regulatory staff person, either party may fulfill this requirement.

The facility administrator is the on-site individual responsible for the day-to-day operation of the facility. The worker shall inform the administrator or designee of the allegations in the complaint. If there is no apparent conflict of interest in doing so, the administrator or designee should be invited to assist with the planning of the investigation. If the administrator or designee chooses not to be involved in the planning process, he shall nevertheless be informed of the progress of the investigation.

5.5.4.1 When the facility administrator or designee is the alleged abuser or neglector

If the administrator or designee is the alleged abuser or neglector, this contact should be initiated with the individual's superior, such as the chairman of the board of directors or the superintendent of schools. If there is no superior, the worker may use discretion in deciding what information to share with the administrator.

5.5.5 Interview alleged victim

> (22VAC40-705-80 B1) The child protective services worker shall conduct a face-to-face interview with and observation of the alleged victim child within the determined response time.

The CPS worker shall conduct at least one (1) face-to-face interview (worker visit) with the alleged victim child and shall conduct this face-to-face interview **within the** determined response time as assessed in Section 3: Complaints and Reports of this manual. A face-to-face interview must be documented as a “worker visit” in the child welfare information system.

The CPS worker shall observe the child and document the child's recollection and perception of the allegations. Information regarding the allegations may be obtained during the CPS worker’s observation of victim interviews conducted by other members of the investigative team including, but not limited to, law-enforcement officers, forensic nurses, physicians or other community professionals trained as forensic interviewers. When possible, it is important to not only observe the interview but also have the ability to ask additional questions as needed. If the CPS worker is not the

primary interviewer, the CPS worker is still responsible for interviewing the child to gather any additional information regarding the allegations and to ensure that the child understands the role of the CPS worker and what will occur during the investigation. The CPS worker must review all electronically recorded victim interviews to determine if additional interviews are necessary to comply with CPS guidance.

The CPS worker must still conduct a face to face interview with the child if the CPS worker is not the primary interviewer of the child regarding the allegations. This worker visit shall be **within the** determined response time.

During the child interview, the CPS worker should inform the child about the investigation and what will occur during the investigation. The CPS worker should note the child's emotional and physical condition (including any injury). The CPS worker should learn about the child's needs and capabilities for the purposes of safety and risk assessment and service planning.

> (22VAC40-705-80 B) During the course of the investigation, the child protective services worker shall document in writing in the state automated system the following contacts and observations. When any of these contacts or observations is not made, the child protective services worker shall document in writing why the specific contact or observation was not made.

The CPS worker shall document all observations and interviews involving the victim child in the child welfare information system. If the face-to-face worker visit with the victim child is not made within the determined response time, this shall be documented in the child welfare information system.

5.5.5.1 Information gathered in the interview with alleged victim child

Collect the following information during the alleged victim interview:

- Demographic information (date of birth, sex, grade in school, etc.).
- Child's developmental level.
- Child's description of the incident including but not limited to:
  - Child's statements about what happened. Include direct quotes of the child if appropriate.

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- Child's statements about the impact of the incident on him.

- Results of any tests or evaluation of the child's injury, behavior, or other characteristics.

- Prior history of abuse or neglect involving the child. The history of any prior abuse or neglect can be provided by any source.

5.5.5.2 Electronic recording

> (22VAC40-705-80.B1.) The child protective services worker shall conduct a face-to-face interview with and observation of the alleged victim child within the determined response time. All interviews with alleged victim children must be electronically recorded.

In 2005, the Virginia Supreme Court of Appeals issued a ruling to affirm the regulatory requirement that victim interviews in an investigation must be electronically recorded according to 22 VAC 40-705-80 or clearly document the specific and detailed reasons for not taping victim interviews as well as the documentation that the decision was made in consultation with a supervisor. A copy of this decision, known as the West Decision, is available on the website of the Virginia Court of Appeals case #2144042.

5.5.5.2.1 Exceptions to electronically recording interviews with the alleged victim child

> (22VAC40-705-80.B1). All interviews with alleged victim children must be electronically recorded except when the child protective services worker determines that:
> a. The child's safety may be endangered by electronically recording his statement;
> b. The age or developmental capacity of the child makes electronic recording impractical;
> c. A child refuses to participate in the interview if electronic recording occurs;
> d. In the context of a team investigation with law-enforcement personnel, the team or team leader determines that electronic recording is not appropriate; or
> e. The victim provided new information as part of a family assessment and it would be detrimental to re-interview the victim and the child protective services worker provides a detailed narrative of the interview in the investigation record.

The VAC provides five (5) exceptions to electronic recording of an interview with an alleged victim child. Before electronically recording an interview with a child, the CPS worker must assess the circumstances surrounding the allegations of abuse or neglect and determine whether any of the five (5) exceptions precluding audio recording the interview apply. Adequately considering the circumstances may include assessing the complaint or report; speaking with the mother, father or guardians of the child; speaking with collateral witnesses; and conducting an assessment of the child.

The CPS worker shall consult with the supervisor when the decision is made not to electronically record an interview with an alleged victim child. The consultation and the specific reasons why electronic recording is not done in the specific investigation shall be documented in the child welfare information system.

- **Exception: The child's safety may be endangered by electronic recording**

If the child's safety is endangered or may be endangered by electronically recording the interview, then the interview must not be electronically recorded. The CPS worker may need to conduct a brief assessment of the child to determine the risk of any harm that may occur to the child as a result of electronically recording the interview. The CPS worker may be able to assess any potential harm to the child by speaking with the child's mother, father or guardians, or collateral witnesses. If the interview is not electronically recorded, the CPS worker shall carefully document the details of the interview in writing for the case record.

- **Exception: The age or developmental capacity of the child makes electronic recording impractical**

The CPS worker must assess the mental and physical capacities of the child. The age or development of the child may preclude electronically recording the interview. It may be appropriate to electronically record the questions being asked by the CPS worker and to describe, either verbally or in writing, the child's responses.

- **Exception: The child refuses to participate in the interview if electronic recording occurs**

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The interview with the child should not be jeopardized because the child refuses to be electronically recorded. If the child refuses to be electronically recorded, the CPS worker should explore the child's reasons and discuss those reasons with the child. If the child still refuses to participate in an electronically recorded interview, then the CPS worker must not electronically record the interview. The CPS worker shall document the reasons why the child refused to be electronically recorded.

- **Exception: In the context of a team investigation, the team or team leader determines that electronic recording is not appropriate**

If a complaint or report of abuse or neglect is being investigated in conjunction with a multidisciplinary team, then the multidisciplinary team should make the decision to electronically record the interview with the alleged victim child based on the specific child and referral. A team investigation includes a joint investigation with the Commonwealth's Attorney office or law enforcement.

- **Exception: The victim provided new information as part of a family assessment**

If the victim provides new information during a family assessment resulting in an investigation and it would be detrimental to re-interview the victim, the CPS worker shall provide a detailed narrative of the interview in the investigation record and document this exception to electronically recording the victim interview.

5.5.5.3 Each interview with the alleged victim child must be electronically recorded

Each interview with the alleged victim child must be electronically recorded unless one (1) of the above mentioned exceptions to electronically recording the interview applies. When an interview is not electronically recorded for any reason, the CPS worker shall complete a detailed summary of the interview, including the reasons for not recording the interview and the supervisory consultation for this decision and enter the information into the automated case record.

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5.5.5.4 Notify the child's parents or caretakers that interview was electronically recorded

While there is no provision in the Code of Virginia or the VAC that requires an LDSS to inform the child's parents that the interview was electronically recorded, the LDSS should notify the mother, father or guardians of the alleged victim child about the interview and that the interview was electronically recorded.

The LDSS should explain to the mother, father or guardians that § 63.2-1518 of the Code of Virginia allows the CPS worker to interview the alleged victim child without the consent of the parents and 22VAC40-705-80 of the VAC requires the interview to be electronically recorded.[1]

5.5.5.5 Parents or caretakers object to electronically recorded interview

There is no provision in the VAC allowing an exception to electronic recording when the mother, father or guardians object to the LDSS electronic recording the interview of the alleged victim child. The CPS worker should explore the foundation for the parents' objection. The objection to the electronic recording may satisfy one of the enumerated exceptions to electronic recording.

5.5.5.6 Equipment malfunction

22VAC40-705-80 B1 provides that a CPS finding may be based on the written narrative should equipment failure occur. If an interview of an alleged victim child is not electronically recorded because of equipment malfunction, then the CPS worker shall write a detailed narrative of the interview and include that narrative in the record.

5.5.6 CPS worker determines who may be present during child interview

> (22VAC40-730-80). Contact with the alleged victim child. The CPS worker shall interview the alleged victim child and shall determine along with a regulatory staff person or facility administrator or designee who may be present in the interview. Where there is an apparent

[1] VA Code § 63.2-1518 provides any person required to make a report of abuse or neglect with the authority to talk to a child suspected of being abused or neglected outside the presence of the child's parents, guardian, other person standing in loco parentis or school personnel. 22 VAC 40-705-80 B requires that any interview by a CPS worker with an alleged victim child be electronically recorded.

> conflict of interest, the local department shall use discretion regarding who is to be included in the interview.

When the CPS worker is conducting an interview with the alleged victim child, the CPS worker shall determine who may be present during the interview, taking into consideration both the comfort of the child and other parties' need to have first-hand information. The CPS agency has the final authority over who may be present if there is no consensus between CPS worker, regulatory staff, and/or facility administrator or designee when issues arise such as the discomfort of the interviewee or an apparent conflict of interest.

5.5.7 Notify parents or guardian of the child

The mother and father, guardian or agency holding custody should be informed of their child's interview and the investigative process in advance; when this is not practical, they shall be informed as quickly as possible after the interview.

The investigative process should be explained to the child's parents, guardian, or agency holding custody. The child's mother and father, guardian or agency holding custody should be interviewed to obtain information about the child and about their knowledge of the allegations and the facility.

The child's mother, father, guardian, or agency holding custody should be kept informed of sufficient information to involve them in planning and support for the child.

5.5.8 Interview alleged abuser or neglector

> (22VAC40-730-90). Contact with the alleged abuser or neglector.
>
> A. The CPS worker shall interview the alleged abuser or neglector according to a plan developed with the regulatory staff person, facility administrator, or designee. Where there is an apparent conflict of interest, the local department shall use discretion regarding who is to be included in the interview. At the onset of the initial interview with the alleged abuser or neglector, the CPS worker shall notify him in writing of the general nature of the complaint and the identity of the alleged victim child to avoid any confusion regarding the purpose of the contacts.
>
> B. The alleged abuser or neglector has the right to involve a representative of his choice to be present during his interviews.

The alleged abuser or neglector shall be given written notice of the CPS report, "Child Protective Services: A Guide to Investigative Procedures in Out of Family Settings."

5.5.8.1 Inform alleged abuser or neglector of right to electronically record interview

> (22VAC40-705-80 B4a). The child protective services worker shall inform the alleged abuser or neglector of his right to electronically record any communication pursuant to § 63.2-1516 of the Code of Virginia.

5.5.8.2 Law enforcement or Commonwealth's Attorney objects to informing the alleged abuser or neglector of his right to record the interview

A law enforcement officer or the Commonwealth's Attorney may object to the LDSS informing the alleged perpetrator of his right to electronically record an interview. If a law-enforcement officer or a Commonwealth's Attorney objects, then the LDSS shall not advise the alleged perpetrator of that right. This objection applies when the Commonwealth's Attorney or the law enforcement officer believes that the instruction will compromise the investigation of any criminal charges.

This objection must be documented in the child welfare information system.

5.5.8.3 LDSS shall provide recording equipment upon request

> (22VAC40-705-80 B4b). If requested by the alleged abuser or neglector the local department shall provide the necessary equipment in order to electronically record the interview and retain a copy of the electronic recording.

The CPS worker must be prepared to provide the equipment should the alleged abuser or neglector elect to electronically record the interview. The LDSS must provide a copy of the electronically recorded interview to the alleged abuser or neglector upon request.

5.5.8.4 Use of statements as evidence

The Code of Virginia § 63.2-1503 M provides that statements made by the alleged abuser or neglector to the investigating CPS worker after the alleged abuser or neglector has been arrested are not admissible in any criminal

proceedings unless the alleged abuser or neglector was advised of his rights against self-incrimination. If a person suspected of abuse or neglect is arrested, that person must be advised of his rights against self-incrimination or any subsequent statements made by the person cannot be used during the criminal proceedings. This section of the Code of Virginia only pertains to the admissibility in criminal proceedings of statements made by the alleged abuser or neglector after that person has been arrested. This section of the Code of Virginia does not pertain to the use of any statements made by the alleged abuser or neglector in determining whether the complaint or report is founded or unfounded. While certain statements made by the alleged abuser or neglector may not be admissible in a court of law, there is no specific exclusion to the LDSS using those statements in determining a founded or unfounded disposition.

5.5.9 Interview collateral children

> (22VAC40-730-100). Contact with collateral children. The CPS worker shall interview non-victim children as collaterals if it is determined that they may have information which would help in determining the finding in the valid complaint. Such contact should be made with prior consent of the non-victim child's parent, guardian or agency holding custody. If the situation warrants contact with the non-victim child prior to such consent being obtained, the parent, guardian or agency holding custody should be informed as soon as possible after the interview takes place.

5.5.10 Observe environment where the alleged abuse or neglect occurred

> (22VAC40-705-80 B7). The child protective services worker shall observe the site where the alleged incident took place.

5.6 Assess safety

The VAC provides regulatory authority to conduct the safety assessment in OOF investigations:

> (22VAC40-730-30). If the complaint information received is such that the local department is concerned for the child's immediate safety, contact must be initiated with the facility administrator immediately to ensure the child's safety. If, in the judgment of the child protective services worker, the situation is such that the child or children should be immediately removed from the facility, the parent or parents, guardian or agency holding

> custody shall be notified immediately to mutually develop a safety plan which addresses the child's or children's immediate safety needs.

The safety assessment focuses on the child and the child's immediate needs. Factors to consider when assessing the immediate situation of the child include:

- Whether the child has sustained a mental or physical injury warranting immediate attention or care;
- Whether an emergency or crisis situation exists meriting immediate action to protect the child;
- Whether the child is at risk of serious abuse or neglect in the near future.

5.6.1 Assess immediate needs of the family or facility

After assessing the immediate safety needs of the child, the worker must evaluate the immediate needs of the family or facility. Factors to consider include:

- If the child has been injured or harmed, whether the family or facility has the capabilities or capacity to protect the child from further harm;
- Whether an emergency or crisis situation exists and the family's or facility's ability to cope;

5.6.2 Assess immediate danger to the other children in the family or facility

After assessing the immediate safety needs of the child and family or facility, the worker must evaluate the immediate needs of any other children in the care of the family or facility. Factors to consider include:

- Whether any other child in the family or facility has sustained a mental or physical injury warranting immediate attention or care
- Whether any other children are at risk of harm or danger
- Whether an emergency or crisis situation exists meriting immediate action to protect the other child(ren) in the home or facility

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- Whether the family or facility has the capability or capacity to protect other children from further harm;

5.6.3 Make safety decision

After safety and protective factors have been assessed, the CPS worker must make a decision about the safety of the child(ren) in the home or facility. The safety decision should be made on the basis of the needs of the least safe child in the home or facility, if there is more than one (1) child. One of the following safety decisions must be determined and documented in the child welfare information system and shared with the family or facility.

- **SAFE**. There are no children likely to be in immediate danger of serious harm at this time. No safety plan is required.
- **CONDITIONALLY SAFE**. Protective safety interventions have been taken and have resolved the unsafe situation for the present time. A safety plan is required to document the interventions.
- **UNSAFE**. Without controlling intervention(s) a child is in immediate danger of serious harm. A court order is required to document intervention.

5.6.4 Emergency removal of child in OOF investigations

If the CPS worker is concerned for the child's immediate safety and the situation is such that the child should be immediately removed from the facility, the mother, father, guardian or agency holding custody and the facility administrator shall be notified immediately to mutually develop a safety plan providing for the child's safety. Written notification shall be provided to the mother, father, guardian or agency holding custody and the facility at the time of the removal.

> (22VAC40-730-40). The authority of the local department to investigate valid complaints of alleged child abuse or neglect in regulated facilities overlaps with the authority of the public agencies which have regulatory responsibilities for these facilities to investigate alleged violations of standards.
>
> (22VAC40-730-40.1). For valid complaints in state regulated facilities and religiously exempted child day programs, the local department shall contact the regulatory authority and share the valid complaint information. The regulatory authority will appoint a staff person to participate in the investigation to determine if there are regulatory concerns.

5.7 Risk assessment and disposition

5.7.1 Risk assessment

> (22VAC40-705-110 B) In all completed family assessments and investigations, the child protective services worker shall conduct a risk assessment to determine whether or not the child is in jeopardy of future abuse or neglect and whether or not intervention is necessary to protect the child.

The decision on risk of future harm should be based on the assessment of individual, family, facility, and other risk factors. Any identified services for the family or caretaker should be based on the needs identified, which is documented in the automated information system. The outcome of the risk assessment will influence the type and intensity of services to be provided. One of these outcomes must be documented in the child welfare information system.

- **Low**. The assessment of risk related factors indicates that there is a low likelihood of future abuse or neglect and no further intervention is necessary.
- **Moderate**. The assessment of risk related factors indicates that there is a moderate likelihood of future abuse or neglect and minimal intervention may be needed.
- **High**. The assessment of risk related factors indicates that there is a high likelihood of future abuse or neglect without intervention.
- **Very High**. The assessment of risk-related factors indicates there is a very high likelihood of future abuse or neglect without intervention.

5.7.2 Disposition and consult with CPS Regional Consultant

The CPS worker and supervisor must consult with CPS regional consultant prior to making a finding and notifying the alleged abuser/neglector of the disposition. This shall not interfere with the requirement to complete the investigation in the legislatively mandated time frame of 45 days. (60 or 90 days when an extension is documented to be necessary)

> (22VAC40-705-10). "Disposition" means the determination of whether or not child abuse or neglect has occurred.

DRAFT

> (22VAC40-705-110.C). In investigations, the child protective services worker shall make a disposition of either founded or unfounded as defined in 22VAC40-705-10 after collecting and assessing information about the alleged abuse or neglect.

After collecting evidence and before expiration of the time frames for completing the investigation, the CPS worker shall determine the disposition. The VAC provides the definition of disposition.

5.7.2.1 Unfounded disposition

The definition of an unfounded disposition as defined in the VAC is:

> (22VAC40-705-10). "Unfounded" means that a review of the facts does not show by a preponderance of the evidence that child abuse or neglect occurred.

However, an unfounded disposition may not mean that abuse or neglect did not occur, but rather that the evidence obtained during the investigation did not reach the preponderance level.

5.7.2.2 Founded disposition

The definition of a founded disposition is found in the VAC:

> (22VAC40-705-10) "Founded" means that a review of the facts shows by a preponderance of the evidence that child abuse or neglect has occurred. A determination that a case is founded shall be based primarily on first source evidence; in no instance shall a determination that a case is founded be based solely on indirect evidence or an anonymous complaint.

See Appendix E for a sample format for documenting a founded dispositional assessment in the child welfare information system.

5.7.2.2.1 Preponderance of the evidence

The VAC defines a preponderance of the evidence as:

> (22VAC40-705-10). "Preponderance of evidence" means just enough evidence to make it more likely than not that the asserted facts are true. It is evidence which is of greater weight or more convincing than the evidence offered in opposition.

DRAFT

As the standard of proof in making a founded disposition of abuse or neglect, a preponderance of the evidence means that the evidence offered in support of the allegation is of greater weight than the evidence offered in opposition. The evidence gathered should be evaluated by its credibility, knowledge offered and information provided.

Proof of one or more of the following factors, linking the abuse or neglect to the alleged abuser or neglector, may constitute preponderance of evidence:

- Medical or psychological information from a licensed medical professional or other treatment professional that indicates that child abuse/neglect occurred.
- An admission by the alleged abuser/neglector.
- The statement of a credible witness or witnesses regarding the abuse or neglect.
- The victim child's statement that the abuse occurred. In assessing the weight to be given to the child's statement, consider:
    - level of detail described;
    - emotional/cognitive developmental level of the child;
    - consistency of statements if more than one interview is conducted;
    - corroboration of statement by other circumstances and/or witnesses;
    - secrecy- child instructed, asked, or threatened to keep the sexual abuse a secret; or
    - coercion- child reports elements of coercion, persuasion, or threats by the alleged abuser to engage in the sexual abuse.
- Circumstantial evidence, or indirect evidence, which links the alleged abuser or neglector to the abuse or neglect.

5.7.2.2.2 First source, direct and indirect evidence

First source evidence and indirect evidence are defined in the VAC:

> (22VAC40-705-10) "First source" means any direct evidence establishing or helping to establish the existence or nonexistence of a fact. Indirect evidence and anonymous complaints do not constitute first source evidence.
>
> "Indirect Evidence" means any statement made outside the presence of the child protective services worker and relayed to the child protective services worker as proof of the contents of the statement.

In no instance can a founded disposition be based solely on indirect evidence or an anonymous complaint.

- **First source or direct evidence**. First source or direct evidence means evidence that proves a fact, without an inference or presumption, and which in itself, if true, conclusively establishes that fact. First source evidence includes the parties and witnesses to the alleged abuse or neglect. First source evidence also includes: witness depositions; police reports; photographs; medical, psychiatric and psychological reports; and any electronic recordings of interviews.

- **Direct evidence** may include witnesses or documents. For example, first source evidence would include a witness who actually saw the alleged act or heard the words spoken. First source evidence would also include the examining physician's report establishing that the child sustained a spiral fracture.

- **Indirect evidence**. Indirect evidence, also known as circumstantial evidence, is evidence based on inference and not on personal knowledge or observation.[6] Indirect evidence relies upon inferences and presumptions to prove an issue in question and may require proving a chain of circumstances pointing to the existence or non-existence of certain facts.

5.7.2.2.3 Credibility of evidence

There is no clear distinction between the reliability and credibility of first source evidence and indirect evidence. It remains incumbent upon the LDSS to weigh the credibility of all the evidence when determining a disposition.

DRAFT

Indirect evidence may be used in support of a founded disposition; however, indirect evidence cannot be the sole basis for the disposition.

5.7.2.3 Determine level of founded disposition

A founded disposition must be categorized into one of three levels. Categorization is dependent on the nature of the act and the seriousness of the harm or threatened harm to the child as a result of maltreatment. In all founded cases, there may be circumstances influencing the severity of the abusive or neglectful incident. The circumstances may increase or decrease the severity of harm or threatened harm.

The level for a founded disposition must be supported by a preponderance of the evidence. The evidence supporting the level must be documented in the record. The facts supporting the level will relate to the type and pattern of abuse/neglect, the vulnerability of the child, the effect or potential effect of the abuse/neglect, and the action or inaction of the caretaker.

5.7.2.3.1 Level 1

> (22VAC40-705-110 D1) Level 1. This level includes those injuries or conditions, real or threatened, that result in or were likely to have resulted in serious harm to a child.

Examples of injuries or conditions that resulted in or were likely to have resulted in serious harm include but are not limited to:

- For physical abuse:
  - the situation requires medical attention in order to be remediated;
  - the injury may be to the head, face, genitals, or is internal and located near a vital organ;
  - injuries located in more than one place;
  - injuries were caused by the use of an instrument such as a tool or weapon;
  - an inappropriate drug was administered or a drug was given in an inappropriate dosage; or

- child exposed to the production or sale of methamphetamine or other drug and is not able to self-protect.

- For neglect situations:
  - the condition would be one where the child's minimal needs are rarely met for food, clothing, shelter, supervision, or medical care;
  - the child is frequently unsupervised or unprotected;
  - the child is left by the caretaker with no plan for the child's care or no information about the caretaker's whereabouts or time for return; or
  - a young child is left alone for any period of time.
- For mental abuse or neglect:
  - the child has engaged in self-destructive behavior;
  - has required psychiatric hospitalization;
  - has required treatment for severe dysfunction;
  - presents a danger to self or others; or
  - problems related to the caretaker behavior.
- For sexual abuse:
  - the situation would be one where there was genital contact;
  - force or threat was used; or
  - the abuse had taken place over a period of time and there were multiple incidents.
- For medical neglect:
  - caretaker failed to provide medical care in a life threatening situation; or
  - a situation that could reasonably be expected to result in a chronic debilitating condition.

DRAFT

- For non-organic failure to thrive: the syndrome is considered to be a form of physical or emotional maltreatment. (refer to physical or mental abuse or neglect above)

5.7.2.3.2 Level 2

> (22VAC40-705-110 D2). Level 2. This level includes those injuries or conditions, real or threatened, that result in or were likely to have resulted in moderate harm to a child.

Examples of injuries or conditions that resulted in or were likely to have resulted in moderate harm include but are not limited to:

- For physical abuse:
  - the injury necessitates some form of minor medical attention;
  - injury on torso, arms, or hidden place (such as arm pits);
  - use of tool that is associated with discipline such as a switch or paddle; or
  - exposure to the production or sale of methamphetamine or other drugs and the child may not be able to self-protect.
- For neglect situations:
  - the condition would be one where the child's minimal needs are sporadically met for food, clothing, shelter, supervision, or medical care; or
  - a pattern or one-time incident related to lack of supervision caused or could have caused moderate harm.
- For mental abuse or neglect:
  - the situation would be one where the child's emotional needs are rarely met; or
  - the child's behavior is problematic at home or school.
- For sexual abuse:

DRAFT

- minimal or no physical touching but could be exposure to masturbation, exhibitionism, etc.;
- caretaker makes repeated sexually provocative comments to the child; or
- child is exposed to pornographic materials.

- For medical neglect:
  - the situation is one in which a doctor has prescribed care to eliminate pain or remedy a condition but the caretaker has not followed through with appointments or recommendations; or
  - the child's condition is not acute or life threatening but could be detrimental to the child's mental or physical health.

  For non-organic failure to thrive, the syndrome is considered to be a form of physical or emotional maltreatment. (refer to physical or mental abuse or neglect above)

5.7.2.3.3 Level 3

> (22VAC40-705-110 D3). Level 3. This level includes those injuries or conditions, real or threatened, that result in minimal harm to a child.

Examples of injuries or conditions that resulted in or were likely to have resulted in minimal harm include but are not limited to:

- For physical abuse:
  - the situation requires no medical attention for injury;
  - minimal exposure to the production or sale of methamphetamine or other drugs.

- For physical neglect:
  - child's minimal needs inconsistently met for food, clothing, shelter, supervision, or medical care; or
  - supervision marginal which poses a threat of danger to child.

DRAFT

- For mental abuse or neglect the situation would be one where the child's emotional needs are met sporadically with evidence of some negative impact on the child's behavior.

- For sexual abuse:

  - there was no or minimal physical touching;

  - exposure to sexual acts such as masturbation, exhibitionism, etc.; or

  - caretaker's actions or behavior, such as making sexually suggestive comments to the child, causes or creates a threat of minimal harm to the child.

- For medical neglect, the situation may be one in which the child's life is not in danger, the child is not experiencing discomfort at this time, but the medical authority reports medical treatment is needed to avoid illness or developmental delay.

- For non-organic failure to thrive, the syndrome is considered to be a form of physical or emotional maltreatment. (refer to physical or mental abuse or neglect above)

5.8 Concerns for other children in the care of the alleged abuser/neglector

In certain OOF investigations, the type or extent of abuse or neglect may increase the concern for other children in the care of the alleged abuser or neglector including children in the alleged abuser or neglector's household or other workplace or OOF setting.

If the information gathered during the investigation gives the LDSS a concern for the safety of other children in the care of the alleged abuser, then the LDSS may wish to consult with legal counsel to determine what additional actions may be needed and permitted. These could include, but are not limited to, new referrals for investigations/assessments, voluntary family service cases, notification to other OOF settings, referral to the regulatory agency, and consultation with law enforcement.

5.9 Notifications for OOF investigations

Refer to Part 4, Family Assessment and Investigation, for notification requirements for all CPS investigations. There are additional notifications required in OOF investigations in designated settings.

5.9.1 Release of information in joint investigations with law enforcement

> (§63.2-1516.1)B. In all cases in which an alleged act of child abuse or neglect is also being criminally investigated by a law-enforcement agency, and the local department is conducting a joint investigation with a law-enforcement officer in regard to such an alleged act, no information in the possession of the local department from such joint investigation shall be released by the local department except as authorized by the investigating law-enforcement officer or his supervisor or the local attorney for the Commonwealth.

5.9.2 Consult with regional consultant

> (22VAC40-730-60) C. At the conclusion of the investigation the local agency shall contact the department's regional CPS coordinator to review the case prior to notifying anyone of the disposition. The regional coordinator shall review the facts gathered and policy requirements for determining whether or not abuse or neglect occurred. However, the statutory authority for the disposition rests with the local agency. This review shall not interfere with the requirement to complete the investigation in the legislatively mandated time frame.

The CPS worker and supervisor shall consult with the regional consultant to review the investigation finding before notifying anyone of the disposition. Although the LDSS is responsible to make the investigation disposition, the regional consultant shall review the investigation and provide technical assistance if needed to ensure the LDSS has conducted the investigation according to CPS regulations and guidance. This may be done by sending an e-mail and including a brief case summary and justification for the final disposition.

5.9.3 Notification to Interstate Compact on the Placement of Children (ICPC)

When applicable, at the conclusion of all investigations, regardless of disposition, notify Interstate Compact for the Placement of Children (ICPC) of the results. The CPS worker shall document this notification in the state child welfare information system.

5.9.4 Written notification to alleged abuser/neglector

See Appendix D for sample letters of notification to the alleged abuser or neglector.

5.9.4.1 Unfounded disposition

> *(§ 63.2-1514 B of the Code of Virginia) [continued] The record of unfounded investigations that involved reports of child abuse or neglect shall be purged three years after the date of the complaint or report if there are no subsequent complaints or reports regarding the same child or the person who is the subject of the complaint or report within such three-year period.*

The alleged abuser or neglector shall be notified in writing that the complaint was determined to be unfounded. A copy of the notification shall be filed in the record and documented in the child welfare information system. The notification shall include the length of time the CPS report will be retained in the child welfare information system; the individual's right to request the record be retained for an additional period; and the right to access information about himself in the investigative record.

Although verbal notification of an unfounded investigation is not required by regulation, CPS workers are encouraged to discuss the outcome of the investigation as well as any services the family may need or request.

5.9.4.2 Founded disposition

The written notification to the abuser or neglector of the founded disposition(s) must be in a letter and a copy must be included in the case record.

The letter must include:

- Summary of the investigation and an explanation of how the information gathered supports the disposition.
- A clear statement that the individual is the abuser and/or neglector.
- The category of abuse or neglect.
- The disposition, level, and retention time, including statement about effect of multiple complaints on retention.

DRAFT

- The name of the victim child or children.
- A statement informing the abuser of his or her right to appeal the finding and to have access to the case record.
- A statement informing the abuser that pursuant to § 63.2-1505 (7) of the Code of Virginia, if the abuser is a teacher in a public school division in Virginia, the local school board shall be notified of the founded disposition.

The abuser or neglector must be informed of his right to appeal the founded disposition. This must be done verbally and in writing as soon as the disposition is reached. In addition, the abuser or neglector must be given a brochure, "Child Protective Services Appeals and Fair Hearings" that outlines the administrative appeal process. The LDSS must document in the child welfare information system that the abuser or neglector was given the appeal brochure and was informed verbally of his or her appeal rights.

LDSS are encouraged to send the disposition letter by certified mail as further documentation of the notification to the abuser or neglector.

5.9.4.2.1 Additional notification to alleged abuser in certain founded sexual abuse investigations

The Code of Virginia § 63.2-1514 A requires that all records related to founded cases of child sexual abuse involving injuries or conditions, real or threatened, that result in or were likely to have resulted in serious harm to a child shall be maintained by the LDSS for a period of 25 years from the date of the complaint. All investigation records founded on or after July 1, 2010 for sexual abuse investigations level 1 shall be maintained by the LDSS 25 years from the date of the complaint. This retention timeframe will not be reflected in the Central Registry past the purge dates set out in 22 VAC 40-705-130 B3.

For all sexual abuse investigations founded level 1 on or after July 1, 2010, the written notification shall include a statement informing the alleged abuser that the investigation record shall be maintained by the LDSS for 25 years past the date of the complaint pursuant to § 63.2-1514 A of the Code of Virginia; however, this retention time will not be reflected in the Central Registry past the purge date of 18 years as set out in 22 VAC 40-705-130 B4.

5.9.4.2.2 Notify abuser or neglector verbally

The verbal notification to the abuser or neglector of the founded disposition(s) should include the disposition, level, and retention time, including effect of multiple complaints on retention and inform the abuser of his or her right to appeal to finding and to have access to the case record. The worker must document in the child welfare information system, the date the verbal notification took place. If the verbal notification did not occur, the CPS worker should document the reasons in the child welfare information system.

5.9.5 Notification to facility administrator and regulatory staff

> (22 VAC 40-730-110). Report the findings. Written notification of the findings shall be submitted to the facility administrator or designee and the regulatory staff person involved in the investigation, if applicable, at the same time the alleged abuser or neglector is notified.
>
> If the facility administrator is the abuser or neglector, written notification of the findings shall be submitted to his superior if applicable.

The CPS worker shall provide a verbal notification of the disposition and a written report of the findings to the facility administrator and, if applicable, to the involved regulatory staff person, the local approval agent and/or the Superintendent in a public school, as soon as practicable after the disposition is made.

This report of the findings shall include:

- Identification of the alleged abuser or neglector and victim, the type of abuse or neglect, and the disposition.
- A summary of the investigation and an explanation of how the information gathered supports the disposition.

5.9.5.1 Notification for school employees

In OOF investigations involving school employees, the LDSS shall provide additional notifications pursuant to §§ 63.2-1503 P and 63.2-1505 B(7) of the Code of Virginia. See Section 5.10.31.1 and Section 5.10.3.2 for specific information.

5.9.6 Notification to parent, guardian, or custodial agency of victim child

> (22 VAC 40-705-140 C2). When the disposition is founded, the child protective services worker shall inform the parents or guardian of the child in writing, when they are not the abuser or neglector, that the complaint involving their child was determined to be founded and the length of time the child's name and information about the case will be retained in the Central Registry. The child protective services worker shall file a copy in the case record.

The mother and father, guardian or custodial agency of the child shall be notified in writing of the disposition of the complaint involving their child. Verbal notification and explanation of the findings are also required. The worker may use discretion in determining the extent of investigative findings to be shared; however, sufficient detail must be provided for the child's custodian to know what happened to his child and to make plans for any needed support and services.

The Code of Virginia § 63.2-1515 requires that when the child has been abused in certain OOF settings the parental notification must advise the parents that the child's name will only be retained in the Central Registry if the parent or guardian grants permission within 30 days of the supervisory approval of the findings.

The notification letter to mother and father, guardian or custodial agency must include the following information:

"If you want your child's name to remain in the Central Registry for as long as the record of the investigation is retained, send a letter to the CPS Unit, Virginia Department of Social Services, 801 East Main Street, Richmond, Virginia 23219. Include your child's name, date of birth, address, and description of the relationship of the abuser to the child."

When the mother, father, guardian or custodial agency requests the child's name to be retained, the disposition level will determine the purge date for the identifying information on the child.

See Appendix D for sample letters of notification to parents, guardian or legal guardian.

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5.9.7 Document all notifications in the automated data system

Each written notification shall be documented in the child welfare information system, identifying all recipients, and identifying where a copy of each written notification can be found.

5.9.8 All other inquiries referred to facility administrator

The CPS worker must refer any inquiries about the findings to the facility administrator or his superior and, when applicable, to the regulatory authority.

5.9.9 Notify Family Advocacy Program

The Code of Virginia § 63.2-1503 N establishes the authority for the LDSS to share CPS information with family advocacy representatives of the United States Armed Forces.

> (§ 63.2-1503 N of the Code of Virginia) Notwithstanding any other provision of law, the local department, in accordance with Board regulations, shall transmit information regarding reports, complaints, family assessments, and investigations involving children of active duty members of the United States Armed Forces or members of their household to family advocacy representatives of the United States Armed Forces.

Effective July 1, 2017: at the conclusion of all investigations (founded and unfounded dispositions), the LDSS shall notify the Family Advocacy Program representative and provide the final disposition, the type(s) of abuse or neglect, the identity of the abuser or neglector and any recommended services. These notifications allow for coordination between CPS and the Family Advocacy Program and are intended to facilitate identification, treatment and service provision to the military family. For additional information about the Family Advocacy Program, contact information for a particular branch of the military or a specific installation, click here.

- Written notification to Family Advocacy shall be made upon completion of an investigation resulting in an unfounded disposition.
- The Family Advocacy Program representative shall be notified in writing within 30 days after all administrative appeal rights of the abuser or neglector have been exhausted or forfeited for all investigations with a founded disposition.
- Written notification to abuser or neglector.

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The abuser or neglector shall be advised that this information is being provided to the Family Advocacy Program and shall be given a copy of the written notification sent to the Family Advocacy Program. These notifications shall be documented in the child welfare information system.

5.9.10 Founded disposition on a foster parent

(22 VAC 40-705-140 B2). When the abuser or neglector in a founded disposition is a foster parent of the victim child, the local department shall place a copy of this notification letter in the child's foster care record and in the foster home provider record.

5.10 Conduct investigations involving public school employees

The Code of Virginia sets out special conditions when investigating complaints of abuse or neglect by public school employees in their official or professional capacity.

(§ 63.2-1511). A. If a teacher, principal or other person employed by a local school board or employed in a school operated by the Commonwealth is suspected of abusing or neglecting a child in the course of his educational employment, the complaint shall be investigated in accordance with §§ 63.2-1503, 63.2-1505, and 63.2-1516.1. Pursuant to § 22.1-279.1, no teacher, principal or other person employed by a school board or employed in a school operated by the Commonwealth shall subject a student to corporal punishment. However, this prohibition of corporal punishment shall not be deemed to prevent (i) the use of incidental, minor or reasonable physical contact or other actions designed to maintain order and control; (ii) the use of reasonable and necessary force to quell a disturbance or remove a student from the scene of a disturbance that threatens physical injury to persons or damage to property; (iii) the use of reasonable and necessary force to prevent a student from inflicting physical harm on himself; (iv) the use of reasonable and necessary force for self-defense or the defense of others; or (v) the use of reasonable and necessary force to obtain possession of weapons or other dangerous objects or controlled substances or paraphernalia that are upon the person of the student or within his control. In determining whether the actions of a teacher, principal or other person employed by a school board or employed in a school operated by the Commonwealth are within the exceptions provided in this section, the local department shall examine whether the actions at the time of the event that were made by such person were reasonable.
B. For purposes of this section, "corporal punishment," "abuse," or "neglect" shall not include physical pain, injury or discomfort caused by the use of incidental, minor or reasonable physical contact or other actions designed to maintain order and control as permitted in clause (i) of subsection A or the use of reasonable and necessary force as permitted by clauses (ii),

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(iii), (iv), and (v) of subsection A, or by participation in practice or competition in an interscholastic sport, or participation in physical education or an extracurricular activity.
C. If, after an investigation of a complaint under this section, the local department determines that the actions or omissions of a teacher, principal, or other person employed by a local school board or employed in a school operated by the Commonwealth were within such employee's scope of employment and were taken in good faith in the course of supervision, care, or discipline of students, then the standard in determining if a report of abuse or neglect is founded is whether such acts or omissions constituted gross negligence or willful misconduct.

5.10.1 Additional requirements

CPS allegations against public school employees have additional considerations which go beyond the normal procedures and requirements for CPS investigations. See Appendix A: Guide for Assessing Applicability of § 63.2-1511 in CPS Out-of-Family Investigations of School Employees for further information.

5.10.1.1 Establish additional validity requirement

In addition to the four validity criteria for all CPS complaints or reports, pursuant to Code of Virginia § 63.2-1511 B, the LDSS shall consider whether the school employee used reasonable and necessary force to maintain order and control. The use of reasonable and necessary force does not constitute a valid CPS report.

5.10.1.2 "Gross negligence" or "willful misconduct" for founded disposition

When the investigation is completed, the standard to make a founded disposition in addition to the preponderance of the evidence is whether such acts or omissions constituted "gross negligence" or "willful misconduct." Otherwise, such acts should be considered within the scope of employment and taken in good faith in the course of supervision, care or discipline of students.

The Supreme Court of Virginia defines "gross negligence" as "that degree of negligence which shows indifference to others as constitutes an utter disregard of prudence amounting to a complete neglect of the safety of [another]. It must

be such a degree of negligence as would shock fair minded [people] although something less than willful recklessness."[2]

The term "willful misconduct" is not commonly used, rather the most common term is "willful and wanton conduct," which the Supreme Court of Virginia defines as follows:

In order that one may be [found to have committed] willful [sic] or wanton conduct, it must be shown that he was conscious of his conduct, and conscious, from his knowledge of existing conditions, that injury would likely or probably result from his conduct, and that with reckless indifference to consequences he consciously and intentionally did some wrongful act or omitted some known duty which produced the injurious result.[3]

The term "willful misconduct" is most often used in Workers' Compensation cases. It refers to the behavior of the injured employee and usually means that the employee violated a rule or directive of the employer and that action led to the injury.

The courts have used the term "willful misconduct" in discussing cases of gross negligence. This definition of "willful and wanton conduct" is used to define "willful misconduct" in this manual. See Appendix A: Guide for Assessing Applicability of § 63.2-1511 in CPS Out-of-Family Investigations of School Employees for further information.

See Appendix E for a sample format for documenting a founded dispositional assessment. Section 5.17.7 provides additional information to be included when making a finding on a school employee.

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[2] Ferguson v. Ferguson, 212 Va. 86, 92, 181 S.E.2d 648, 653 (1971); see also Meagher v. Johnson, 239 Va. 380, 383, 389S.E.2d 310, 311(1990).

[3] Infant C. v. Boy Scouts of America, 239 Va. 572, 581, 391 S.E.2d 322, (1990).

5.10.1.3 Mandatory timeframe to make disposition

Effective July 1, 2015, § 63.2-1505 mandates the LDSS to make the final disposition of any report involving a public school employee within the established timeframes. The finding must be completed and approved in the child welfare information system and notification made to the alleged abuser or neglector according to the timeframes outlined in § 63.2-1505 B5.

> (§ 63.2-1505 B5). 5. Determine within 45 days if a report of abuse or neglect is founded or unfounded and transmit a report to such effect to the Department and to the person who is the subject of the investigation. However, upon written justification by the local department, the time for such determination may be extended not to exceed a total of 60 days or, in the event that the investigation is being conducted in cooperation with a law-enforcement agency and both parties agree that circumstances so warrant, as stated in the written justification, the time for such determination may be extended not to exceed 90 days. If through the exercise of reasonable diligence the local department is unable to find the child who is the subject of the report, the time the child cannot be found shall not be computed as part of the total time period allowed for the investigation and determination and documentation of such reasonable diligence shall be placed in the record. In cases involving the death of a child or alleged sexual abuse of a child who is the subject of the report, the time during which records necessary for the investigation of the complaint but not created by the local department, including autopsy or medical or forensic records or reports, are not available to the local department due to circumstances beyond the local department's control shall not be computed as part of the total time period allowed for the investigation and determination, and documentation of the circumstances that resulted in the delay shall be placed in the record. In cases in which the subject of the investigation is a full-time, part-time, permanent, or temporary employee of a school division who is suspected of abusing or neglecting a child in the course of his educational employment, the time period for determining whether a report is founded or unfounded and transmitting a report to that effect to the Department and the person who is the subject of the investigation shall be mandatory, and every local department shall make the required determination and report within the specified time period without delay;

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5.10.2 Additional procedures for investigations involving public school employees

In addition to the investigation procedures and requirements for other OOF investigations noted in this chapter and in Chapter 4, Family Assessment and Investigation, there are additional procedures applicable to reports involving public school employees.

(§ 63.2-1516.1). Investigation procedures when school employee is subject of the complaint or report.

A. Except as provided in subsection B of this section, in cases where a child is alleged to have been abused or neglected by a teacher, principal or other person employed by a local school board or employed in a school operated by the Commonwealth, in the course of such employment in a nonresidential setting, the local department conducting the investigation shall comply with the following provisions in conducting its investigation:
1. The local department shall conduct a face-to-face interview with the person who is the subject of the complaint or report.
2. At the onset of the initial interview with the alleged abuser or neglector, the local department shall notify him in writing of the general nature of the complaint and the identity of the alleged child victim regarding the purpose of the contacts.
3. The written notification shall include the information that the alleged abuser or neglector has the right to have an attorney or other representative of his choice present during his interviews. However, the failure by a representative of the Department of Social Services to so advise the subject of the complaint shall not cause an otherwise voluntary statement to be inadmissible in a criminal proceeding.

5.10.3 Additional notifications

(§ 63.2-1516.1). 4. Written notification of the findings shall be submitted to the alleged abuser or neglector. The notification shall include a summary of the investigation and an explanation of how the information gathered supports the disposition.
5. The written notification of the findings shall inform the alleged abuser or neglector of his right to appeal.
6. The written notification of the findings shall inform the alleged abuser or neglector of his right to review information about himself in the record with the following exceptions:
a. The identity of the person making the report.
b. Information provided by any law-enforcement official.
c. Information that may endanger the well-being of the child.

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> d. The identity of a witness or any other person if such release may endanger the life or safety of such witness or person.

5.10.3.1 Notify local school board when abuser is an employee

Pursuant to § 63.2-1505 of the Code of Virginia, if at the time of the investigation or the conduct that led to the report, the abuser is or was a full-time, part-time, permanent, or temporary employee in a school division located within the Commonwealth, the LDSS shall notify the local school board of the founded disposition at the same time the subject is notified of the founded disposition. This includes in home investigations when the employee is the subject of the founded investigation involving his own children. Any information exchanged for the purposes of this subsection shall not be considered a violation of §§ 63.2-102, 63.2-104 or 63.2-105.

The LDSS may send a copy of the disposition letter to the subject of the complaint to the local school board to meet this notification requirement.

This notification/referral shall be documented in the child welfare information system.

5.10.3.2 Notify Superintendent of Public Instruction, Department of Education

Pursuant to § 63.2-1503 P of the Code of Virginia, the LDSS shall immediately notify the Superintendent of Public Instruction, Department of Education (DOE) when an individual holding a license issued by the Board of Education is the subject of a founded complaint of child abuse or neglect and shall transmit identifying information regarding such individual if the LDSS knows the person holds a license issued by the Board of Education. Any information exchanged for the purpose of this subsection shall not be considered a violation of §§ 63.2-102, 63.2-104, or 63.2-105 of the Code of Virginia.

The LDSS shall immediately notify the Superintendent of Public Instruction, DOE if the founded complaint of child abuse or neglect is overturned on an administrative appeal.

The Board of Education issues licenses to instructional personnel including teachers and other professionals and administrators. Refer to Licensure Regulations for School Personnel in the VAC.

The Board of Education does not license teacher aides, janitorial staff, and administrative support staff.

This notification requirement applies to all individuals holding a license even if that person is not currently employed by a local school board.

5.11 Interagency agreements with local school division for CPS complaints that require coordination

> (§ 63.2-1511 D of the Code of Virginia) Each local department and local school division shall adopt a written interagency agreement as a protocol for investigating child abuse and neglect reports. The interagency agreement shall be based on recommended procedures for conducting investigations developed by the Departments of Education and Social Services.

LDSS shall adopt a written interagency agreement for complaints of child abuse and neglect that require coordination between local departments and local school divisions to facilitate the investigation or family assessment. The LDSS shall no longer be required to report annually on the status of the interagency agreement to the Board of Social Services unless the interagency agreement is substantially modified. When substantial modifications are made to an interagency agreement, the LDSS must notify the CPS Program Manager.

A model agreement has been developed by the Virginia Department of Education and VDSS with participation of local school divisions and LDSS and can be found on the interagency website and in Appendix B: Recommended Procedures for Local Agreements between Schools and Local Departments of Social Services.

5.12 Services to abuser/neglector in an OOF investigation

Services can be provided to an abuser/neglector in a founded OOF investigation when the risk assessment is high or moderate for the victim child or to other children to whom the abuser/neglector may have access.

Open the CPS on-going case in the name of the abuser/neglector in the child welfare information system.

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5.13 Appendix A: Guide for Assessing Applicability of § 63.2-1511 in CPS OOF Investigations of School Employees

This document is intended as a guideline for CPS OOF investigations involving school personnel in order to review the requirements of § 63.2-1511 of the Code of Virginia which apply to screening validity and dispositional assessments. Section 5 of the CPS chapter provides additional guidance for LDSS in conducting CPS investigations in OOF settings including schools.

CPS allegations against public school employees have additional considerations which go beyond the normal procedures and requirements for CPS investigations. Obtaining a preponderance of evidence to support the standard of gross negligence and willful misconduct for school complaints is difficult considering that there are many players (e.g., school administrators, licensing/regulatory inspectors, law enforcement, parents, or the community) involved in the process. The statutory standard looks at the behavior of the alleged abuser/neglector which must rise to the level of gross negligence or willful misconduct. While this may not "feel" right for the parent, alleged victim, or others who may be impacted by the incident, this standard is set in statute.

In the flow chart that follows, at each decision point there is a list of corresponding discussion questions for consideration pertaining to § 63. 2-1511 moving through the CPS decision process from validity through disposition for allegations against school employees. This is not an exhaustive list of questions (as there are always infinite facts/possibilities to consider in CPS), but a starting point to examine the unique circumstances of each allegation and investigation. Please note that in many circumstances, the answers to each question may not be clear until the investigation has been initiated and more information is needed to proceed through the decision tree, while the answer to other questions may become clear once the investigation comes to a close and an analysis is made.

As with any CPS report or investigation, it is critical to document the facts and evidence gathered to support assessment decisions. Dispositional documentation must address the unique requirements of § 63. 2-1511 of the Code of Virginia related to public school employment, reasonable and necessary force, and gross negligence or willful misconduct.

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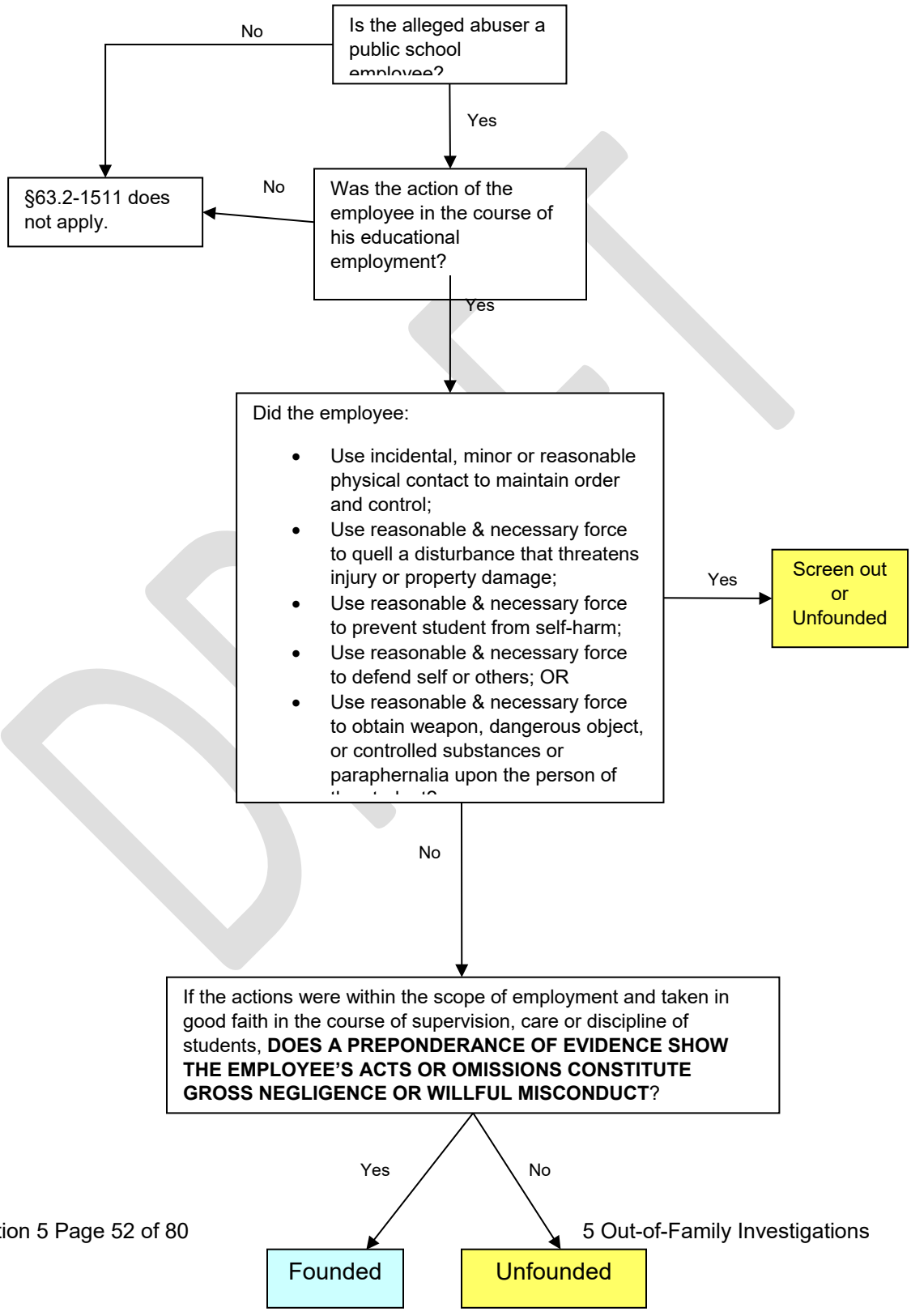
ASSESSING APPLICABILITY OF §63.2-1511 FOR CPS INVESTIGATION



IS THE ALLEGED ABUSER/NEGLECTOR A PUBLIC SCHOOL EMPLOYEE?

If a teacher, principal or other person employed by a local school board or employed in a school operated by the Commonwealth is suspected of abusing or neglecting a child then proceed under § 63.2-1511. § 63.2-1511 does not apply to private schools or their employees who are solely licensed by the Commonwealth and not operated by the Commonwealth. When in doubt, verify with the Monitoring Specialist, Department of Education-State Operated Programs at (804)786-0581. Listings of private schools that are solely licensed by the state can be located at http://www.vcpe.org/.

(IF NO, § 63.2-1511 does not apply.)

IF YES,

WAS THE ACTION OF THE EMPLOYEE IN THE COURSE OF HIS EDUCATIONAL EMPLOYMENT?

Information to gather and consider may include, but is not limited to:

- Was the alleged abuser/neglector acting within the scope of his employment regarding supervision, care or discipline of students?
- What are the job duties, role and responsibilities of the alleged abuser/neglector? (As indicated by the alleged abuser, administrator, or collaterals?)
- Where did the incident occur and under what circumstances?
- Was the alleged abuser/neglector acting on an assignment as part of his employment?

(IF NO, § 63.2-1511 does not apply.)

IF YES,

DID EMPLOYEE USE INCIDENTAL, MINOR OR REASONABLE PHYSICAL CONTACT TO MAINTAIN ORDER AND CONTROL; USE REASONABLE AND NECESSARY FORCE TO

QUELL A DISTURBANCE THAT THREATENS INJURY OR PROPERTY DAMAGE; USE REASONABLE AND NECESSARY FORCE TO PREVENT STUDENT FROM SELF-HARM; USE REASONABLE AND NECESSARY FORCE TO DEFEND SELF OR OTHERS; OR USE REASONABLE AND NECESSARY FORCE TO OBTAIN WEAPON, DANGEROUS OBJECT, OR CONTROLLED SUBSTANCES OR PARAPHERNALIA UPON THE PERSON OF THE STUDENT? (§ 63.2-1511(A) "…prohibition of corporal punishment shall not be deemed to prevent (i) the use of incidental, minor or reasonable physical contact or other actions designed to maintain order and control; (ii) the use of reasonable and necessary force to quell a disturbance or remove a student from the scene of a disturbance that threatens physical injury to persons or damage to property; (iii) the use of reasonable and necessary force to prevent a student from inflicting physical harm on himself; (iv) the use of reasonable and necessary force for self-defense or the defense of others; or (v) the use of reasonable and necessary force to obtain possession of weapons or other dangerous objects or controlled substances or paraphernalia that are upon the person of the student or within his control.")

Information to gather and consider may include, but is not limited to:

- Was there a disturbance where the situation was out of control or going to get out of control?
- Did the alleged abuser use incidental, minor or reasonable physical contact or other actions designed to maintain order and control?
- Were there real or potential threats of physical injury to anyone or damage or potential damage to property?
- Was any student in danger of inflicting physical harm on himself? Were there any weapons, dangerous objects, controlled substances or paraphernalia involved in the incident?
- Was the level of force necessary? Were there any less restrictive or less forceful options used or available to control situation?
- If alleged abuser felt the need for self-defense, what was the perceived threat? What was said by victim, alleged abuser, or others? Were there other options available to the alleged abuser to defend himself before resorting to the use of force? Did the alleged abuser say anything to de-escalate or incite the situation? What explanation did the alleged abuser provide for behavior?
- What did victim and collaterals say about behavior of the alleged abuser/neglector?
- What are school policies regarding discipline, training, restraint, and escalating action?

IF YES, SCREEN OUT / UNFOUND: The use of reasonable and necessary force when acting to maintain order and control, quell a disturbance etc. does not constitute a valid report pursuant to 22VAC40-730-115 B1. Information to make this determination may not be available at initial intake; therefore, an investigation would be initiated. The investigation must be unfounded if after gathering evidence, the LDSS determines that the alleged abuser used

reasonable and necessary force. **It is critical to document the facts and decision in the assessment of reasonable and necessary force.**

IF NO,

IF THE ACTIONS WERE WITHIN THE SCOPE OF EMPLOYMENT AND TAKEN IN GOOD FAITH IN THE COURSE OF SUPERVISION, CARE OR DISCIPLINE OF STUDENTS, DOES A PREPONDERANCE OF EVIDENCE SHOW THE EMPLOYEE'S ACTS OR OMISSIONS CONSTITUTE GROSS NEGLIGENCE OR WILLFUL MISCONDUCT?

Excerpt from CPS Manual Part V: **"**The Supreme Court of Virginia defines "gross negligence" as "that degree of negligence which shows indifference to others as constitutes an utter disregard of prudence amounting to a complete neglect of the safety of [another]. It must be such a degree of negligence as would shock fair minded [people] although something less than willful recklessness." In order that one may be [found to have committed] willful [sic] or wanton conduct, it must be shown that he was conscious of his conduct, and conscious, from his knowledge of existing conditions, that injury would likely or probably result from his conduct, and that with reckless indifference to consequences he consciously and intentionally did some wrongful act or omitted some known duty which produced the injurious result."

Information to consider may include, but is not limited to:

- Would behavior, action, or inaction of alleged abuser shock fair minded people?
- Should the alleged abuser know/suspect that outcome would occur? Was the alleged abuser aware that injury/threat of injury would likely occur based on evidence of similar incidents/history?
- Was there willful misconduct (deliberate, conscious decision to act or not act)?

IF NO = UNFOUNDED

IF YES,

FOUNDED

Analysis of preponderance of evidence clearly documents FACTS to support requirements of § 63.2-1511:

- Alleged abuser acting in good faith within the scope of employment as public school employee.

- Alleged abuser's actions were not reasonable or necessary to quell disturbance etc.
- FACTS/EVIDENCE supports finding determination of gross negligence or willful misconduct.

It is critical to clearly document the assessment of these factors supported by evidence in the dispositional assessment.

REMINDER FOR SCHOOL EMPLOYEES:

Notify the local school board of a founded disposition when the subject of the founded investigation is or was a full-time, part-time, or temporary employee in a school division located within the Commonwealth. Notification to the local school board shall occur at the same time the subject is notified of the founded disposition.

Notify the Superintendent of Public Instruction, DOE when the subject of founded investigation holds a license issued by the Board of Education. Notification to the Superintendent of Public Instruction, DOE shall occur at the same time the subject is notified of the founded disposition.

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5.14 Appendix B: Recommended Procedures for Local Agreements Between School Divisions and Local Departments of Social Services

The following model agreement has been developed by the Virginia Department of Education and the Virginia Department of Social Services (VDSS) with participation from school divisions and local departments of social services (LDSS). This model offers recommended procedures to ensure the coordinated response to reports of child abuse and neglect that come to the attention of public school personnel. (Revised August 2014)

5.14.1 Legal base

- The Code of Virginia § 63.2-1503 designates LDSS as the public agencies responsible for receiving and responding to complaints and reports of child abuse and neglect.

- The Code of Virginia § 63.2-1511 A requires that complaints against teachers, principals or other local school board employees for child abuse and neglect be investigated in accordance with §§ 63.2-1503, 63.2-1505 and 63.2-1516.1 of the Code of Virginia.

- The Code of Virginia § 63.2-1511requires each local department of social services and school division to adopt a written interagency agreement as a protocol for investigation of child abuse and neglect reports.

5.14.2 School division employees' reports of suspected child abuse and neglect

5.14.2.1 Responsibilities of the school division

- The school division will provide information to its personnel regarding the child abuse and neglect requirements (Code of Virginia § 63.2-1509) and local procedures for reporting suspected incidences of child abuse or neglect.

- The school division will identify one person to act as a liaison with the LDSS to facilitate communication and collaboration between both agencies.

- Pursuant to the Code of Virginia, § 63.2-1509, school division employees will report suspected child abuse and neglect within 24 hours of the first suspicion. School division employees shall have the following responsibilities:
    - When a school division employee has information that a child under age 18 may be abused or neglected, the employee must immediately report such suspected child abuse or neglect to the LDSS or to the Virginia State Child Abuse Hotline, **1-800-552-7096**.
    - The school division employee will inform his or her school's administrator or designee of the suspected child abuse or neglect according to the school division's policies and procedures.
    - The school division employee will adhere to the school division procedures and policies as they pertain to documenting the submission of the CPS report of child abuse and neglect.

5.14.2.2 Responsibilities of the LDSS

- The LDSS will identify one person to act as liaison with the school division to facilitate communication and collaboration between both agencies.
- The LDSS will provide information to the school division about how to recognize and report suspected child abuse and neglect.

5.14.3 Investigation or family assessment involving a non-school employee

5.14.3.1 Responsibilities of the School Division

- The school site administrator, or designee, will cooperate with the CPS worker during an investigation or family assessment of child abuse and neglect by a non- school employee by providing the following resources:
    - Documentation and/or information relative to the complaint;
    - Pertinent directory information, such as the child and family's contact information;
    - A room or space to interview children and/or staff that ensures privacy and is free from interruptions. Pursuant to the Code of Virginia, § 63.2-1518,

consent of the parent, legal guardian or school personnel to conduct the CPS interviews at school is not required.

- The Federal Education Rights and Privacy Act (FERPA) prohibits the sharing of student information without explicit parental consent unless the CPS worker has a court order to review the record. However, in an emergency or health/safety situation, the school could provide access to the record. It is the responsibility of the school division to determine what constitutes an emergency.

5.14.3.2 Responsibilities of the LDSS

- The LDSS shall provide information to school division employees about the role and function of the LDSS in responding to reports of suspected child abuse and neglect.
- The LDSS shall have the capability of receiving reports on a 24-hours-a-day, 7-days-a-week basis.
- The Code of Virginia, § 63.2-1503, requires the LDSS to determine the validity of all CPS reports. The Code of Virginia, § 63.2-1508 establishes the following elements for a valid report:
  - the alleged victim is under the age of 18 at the time of the report;
  - the alleged abuser is the alleged victim child's parent or other caretaker;
  - the local department receiving the report has jurisdiction; and
  - the circumstances describe suspected child abuse or neglect as defined in the Code of Virginia § 63.2-100.
- If the report is determined to be valid, the LDSS will conduct a family assessment or investigation.
- Upon receipt of the complaint, the LDSS CPS worker will conduct an immediate investigation or family assessment based on the assessed response time as determined by the CPS Intake Unit. The assigned CPS worker will contact the school site administrator or designee to:
  - Secure further information and/or documentation relative to the complaint;

- Obtain the child and family's contact information;
- Arrange to see and interview the child and siblings at school when necessary. Pursuant to the Code of Virginia, § 63.2-1518, consent of the parent, legal guardian or school personnel to conduct the CPS interviews at school is not required.

- The CPS worker may take photographs of the alleged child victim at school. Consent of the parent or other person responsible for such child to take photographs is not required pursuant to § 63.2-1520 of the Code of Virginia.

- If the initial report was made by a school employee, that individual shall receive a written communication from the LDSS informing them that the investigation or family assessment has been completed and a description of the actions taken.

- Pursuant to the Code of Virginia, § 63.2-1505 B7, if at the time of the investigation or the conduct that led to the report, the abuser is or was a full-time, part-time, permanent or temporary employee in a school division located within the Commonwealth, the LDSS shall notify the relevant school board of the founded disposition at the same time the subject is notified of the founded disposition. This includes founded dispositions in investigations involving the employee's own children or children in the care of the employee.

5.14.4 Investigation of child abuse or neglect by a school employee in the course of his/her employment

5.14.4.1 Responsibility of school division

- During an investigation of child abuse or neglect by a school employee in the course of his/her employment, the school site administrator or designee will determine if he or she will participate in the planning of a joint investigation or if there is a conflict of interest.

- The school site administrator or his or her designee will provide logistical support and information to the CPS worker to assist in the investigation to include:

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- A room or space to interview children and/or staff that ensures privacy and is free from interruptions;
- An escort for the CPS worker to the site of the alleged abuse or neglect;
- Pertinent policies and procedures, such as those related to the use of reasonable force and the use of appropriate restraining techniques;
- Records and written statements pertaining to the alleged abuse or neglect;
- Names, functions and roles of the involved parties;
- Work schedules and contact information of staff;
- Contact information of non-victim children's parents/guardians in order to obtain permission for the CPS worker to interview them.

5.14.4.2 Responsibilities of the LDSS

- The LDSS shall provide information to the school division about the role and function of the LDSS in responding to reports of suspected child abuse and neglect by employees of the school division.
- The LDSS will investigate a complaint of suspected child abuse or neglect involving a teacher, principal or other public school employees pursuant to §§ 63.2-1503, 63.2-1505 and 63.2-1516.1 of the Code of Virginia.
- The LDSS will conduct an immediate investigation upon receipt and validation of a report about suspected incidents of child abuse or neglect by a school employee.
- The LDSS will keep the school site administrator or designee apprised of the investigation's status.
- The LDSS will make a disposition within 45 days, or 60 days when an extension is documented to be necessary, or 90 days if the investigation is being conducted with law enforcement pursuant to § 63.2-1505 of the Code of Virginia.
- The Code of Virginia, § 63.2-1511 C, requires the CPS worker to determine that there was willful misconduct or gross negligence by the

school employee in addition to the standard requiring a preponderance of the evidence for a founded disposition.

- The CPS worker shall provide both verbal and written notification of the findings to the site administrator and the school division's superintendent (22VAC 40-730-110). The written notification must include:
  - The identity of the abuser/neglector and victim, the type of abuse/neglect and the disposition;
  - A summary of the investigation and how the disposition is supported.
- If the initial report was made by a school employee, that individual shall receive a written communication from the LDSS informing them that the investigation has been completed and a description of the action taken.
- Pursuant to § 63.2-1503 P of the Code of Virginia, the LDSS shall immediately notify the Superintendent of Public Instruction, Virginia Department of Education (DOE), when an individual holding a license issued by the Board of Education is the subject of a founded complaint of child abuse or neglect and shall transmit identifying information regarding the individual to the Board of Education. The LDSS shall immediately notify the Superintendent of Public Instruction, DOE if the founded complaint of child abuse or neglect is overturned on an administrative appeal.

5.14.5 Information sharing and confidentiality

- Information shall be shared between the CPS Unit of the LDSS and the school division that is accurate, complete, timely, and pertinent so as to ensure fairness in determination of the disposition of the complaint.
- All information gathered as a result of a child abuse and neglect investigation or family assessment shall be treated confidentially, in accordance with applicable social services and education requirements.
- The Federal Education Rights and Privacy Act (FERPA) prohibits the sharing of student information without explicit parental consent unless the CPS worker has a court order to review the record. However, in an emergency or health/safety situation, the school could provide access to the record. It is the

responsibility of the school division to determine what constitutes an emergency.

5.14.6 Execution of agreement

- The LDSS and school division shall report annually on the status of this agreement to the State Board of Social Services and to the Board of Education, respectively. Once this interagency agreement is adopted, an annual report is not necessary unless the agreement has been substantially modified.

- This Agreement shall become effective immediately upon signature of both parties. Signature of both parties shall constitute acceptance of this Agreement as well as assurance of the distribution and implementation of the procedures described herein. This Agreement shall be reviewed by both parties on a periodic basis or as needed.

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5.15 Appendix C: Checklist for OOF investigations

	CPS RESPONSIBILITY	DATE	CONTACT INFORMATION
1.	Receive report and enter into OASIS.		
2.	Report to Commonwealth Attorney and law enforcement all class 1 misdemeanors /felonies, as per local guidelines.		
3.	Contact CPS Program Consultant (plan investigation strategy).		
4.	If report involves school personnel, refer to Appendix A: Guide for Assessing Applicability of § 63.2-1511 in CPS OOF Investigations of School Employees for guidance on these investigations.		
5.	Contact Regulatory agency, obtain name of staff who will investigate report jointly.		
6.	Contact that regulatory staff person to coordinate strategy of investigation.		
7.	Contact facility administrator to inform of impending visit (or announce presence to administrator upon arrival to facility).		
8.	Meet the licensing or regulatory person, if possible, at facility and go together to meet the administrator. Explain differing roles and expectations.		
9.	Advise administrator (or designee) of the allegations in the complaint. Invite their input for preliminary plans.		
10.	Request of administrator the following resources, as appropriate:		

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	• Private room/space to interview staff and children • Accompaniment to site of alleged abuse • Pertinent policies, records, guidelines • Names, function, roles of all involved parties • Work schedules of alleged abuser/neglector and other staff witnesses • Phone numbers of staff witnesses • Phone number and address for the alleged abuser		
	CPS RESPONSIBILITY	**DATE**	**CONTACT INFORMATION**
11.	Interview the victim child(ren). • The parent, guardian or agency holding custody should be notified in advance; when not practical shall notify as soon as possible. • CPS determines who can be present during this interview. • Record interview.		
12.	Determine immediate Safety (if unsafe and child needs to be removed then the parent, guardian or agency holding custody shall be notified to mutually develop a safety plan).		
13.	Interview collateral children. • Before interviewing collateral children, consent of the child's parent, guardian, or agency holding custody should be obtained.		
14.	Interview alleged abuser/neglector. • Offer electronic recording and provide written notification.		

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15.	Interview collateral staff witnesses.		
16.	Interview victim's parent, guardian or agency holding custody. • They should be informed early in the process about the report. The investigative process should be explained. Obtain information about their knowledge of the allegations and the facility. They should be kept involved in the planning and support of the victim child.		
17.	Keep the facility administrator apprised of the progress of the investigation. If working jointly with regulatory agency, CPS may decide who will perform these progress reports.		
18.	Although statutory authority for the disposition rests with the local agency, at the conclusion of the investigation the CPS worker shall contact the CPS Program Consultant to review the case prior to notifications being sent. This review should include supervisor if possible.		

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	CPS RESPONSIBILITY	DATE	CONTACT INFORMATION
19.	Notifications of disposition made to all parties. The alleged abuser/neglector and facility administrator should be verbally notified promptly. The alleged abuser should be notified first or at least at same time the facility administrator is notified.		
20.	Written report of the findings shall be submitted to the facility administrator and the involved regulatory staff person or school superintendent. This report shall include identification of the alleged abuser and victim as well as a summary of the investigation with an explanation of how the information supports the disposition. A copy of this report shall be sent to the abuser/neglector along with the letter of notification and rights of appeal.		
21.	Written notification of findings sent to the parent, guardian or agency that has custody. A verbal follow up is also encouraged. Parents should be advised that the victim (s) names will be purged after 30 days unless they make a request to keep listed in OASIS.		
22.	**FOR SCHOOL EMPLOYEES**: Notify the local school board of a founded disposition when the subject of the founded investigation is or was a full-time, part-time, or temporary employee in a school division located within the Commonwealth. Notification to the local school board shall occur at the same time the subject is notified of the founded disposition. Notify the Superintendent of Public Instruction, DOE when the subject of founded investigation holds a license issued by the Board of Education. Notification to the Superintendent of Public Instruction, DOE shall occur at the same time the subject is notified of the founded disposition.		

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22.	Post-investigative treatment services may be provided as needed by local agency to the child, family or abuser. Post-investigative corrective action follow up with the facility is the responsibility of the regulator and facility administration.		
23.	**ALL contacts are documented in OASIS.**		

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5.16 Appendix D. Sample Letters of Notification for OOF Investigations

5.16.1 Founded, abuser

DATE

ALLEGED ABUSER
ADDRESS

Dear **ALLEGED ABUSER**:

Thank you for your cooperation during the recent investigation. We are writing to inform you of the disposition of the investigation in which you were named as the alleged abuser/neglector. The report was made in reference to **CHILD(REN) NAMES**. After a thorough investigation and review with my supervisor, we have made a disposition of Founded, **(pick one) LEVEL ONE, TWO or THREE** for **(pick all that apply) PHYSICAL ABUSE; PHYSICAL NEGLECT; MEDICAL NEGLECT; SEXUAL ABUSE; OR MENTAL ABUSE/NEGLECT. (IF MORE THAN ONE TYPE OF ABUSE/NEGLECT OR DIFFERENT LEVELS, ADD SENTENCE FOR EACH; CAN ALSO INCLUDE ANY UNFOUNDED DISPOSITIONS IN SAME LETTER)** "Founded" means that a review of the facts shows by a preponderance of the evidence that child abuse or neglect has occurred.

CHOOSE ONE OF THE FOLLOWING:

A level ONE includes those injuries/conditions, real or threatened, that result in or were likely to have resulted in serious harm to a child. **OR** A level TWO includes those injuries/conditions, real or threatened, that result in or were likely to have resulted in moderate harm to a child. **OR** A level THREE includes those injuries/conditions, real or threatened, that result in or were likely to have resulted in minimal harm to a child.

The parents of the victim child(ren) if not you, have been informed of this disposition. The person who made the report has been advised it is complete and necessary actions have been taken.

CHOOSE ONE OF THE FOLLOWING:

As a result of this disposition, your name and the child's name will be placed in the Virginia Child Abuse and Neglect Central Registry based on the level that was assessed. For founded investigations, level one, names and records are kept for 18 years from the date of the complaint

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if there are no subsequent reports of child abuse/neglect regarding the same child(ren) or alleged abuser/neglector. **OR** For founded investigations, level two, names and records are kept for 7 years from the date of the complaint if there are no subsequent reports of child abuse/neglect regarding the same child(ren) or alleged abuser/neglector. **OR** For founded investigations, level three, names and records are kept for 3 years from the date of the complaint if there are no subsequent reports of child abuse/neglect regarding the same child(ren) or alleged abuser/neglector.

OR IF THE INVESTIGATION WAS SEXUAL ABUSE, LEVEL ONE

For founded investigations, level one, names and records are kept for 18 years from the date of the complaint if there are no subsequent reports of child abuse/neglect regarding the same child(ren) or alleged abuser/neglector. Because this investigation involved serious sexual abuse of a child the investigation record shall be maintained by this agency for 25 years past the date of the complaint pursuant to §63.2-1514 A of the Code of Virginia; however, this retention time will not be reflected in the Central Registry past the purge date of 18 years.

Pursuant to §63.2-1526 of the Code of Virginia, you have the right to appeal this decision. A request to appeal this decision must be made in writing to the director of this agency within thirty (30) days of receipt of this notification. The enclosed brochure, entitled "Child Protective Services Appeals and Fair Hearings" explains the appeals process in more detail. Upon written request, you also have the right receive all information used in making this determination except the name of the complainant and any information that would endanger the safety of any child. Additionally, if you have been charged criminally for the same conduct involving the same child as in this investigation, the appeal process shall be stayed until completion of all criminal prosecution. Your right to access the records of this investigation is also stayed. A written request to appeal this decision must still be submitted within thirty (30) days of receipt of this notification even if there are criminal charges.

(SUMMARY OF INVESTIGATION)

Enclosed is a summary of our investigation and an explanation of how the information gathered supports the founded disposition. (**CAN INSERT SUMMARY HERE)**

As required, we are providing a copy of this notification and summary of findings to the facility administrator or designee and any regulatory agency staff involved in the investigation at the same time we notify you of the disposition.

IF ABUSER IS OR WAS EMPLOYEE OF A SCHOOL DIVISION IN VIRGINA, ADD:

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Pursuant to §63.2-1505 of the Code of Virginia, if at the time of the investigation or the conduct that led to the report, you are or were a full-time, part-time, permanent, or temporary employee in a school division located within the Commonwealth, we are required to notify the local school board of this founded disposition.

Pursuant to §63.1505 of the Code of Virginia, if you hold a license issued by the Virginia Department of Education we are required to notify the Superintendent of Public Instruction, DOE of this founded disposition.

INCLUDE IF NEEDED:

Pursuant to §63.2-1503(N) of the Code of Virginia, we are required to notify the family advocacy representative of the United States Armed Forces if the investigation involved child(ren) of an active duty member of the United States Armed Forces.

If you have any questions, please contact me at **(___)___-____.**

Sincerely,

CPS WORKER NAME
CPS SUPERVISOR NAME

Cc: Facility Administrator
Regulatory Staff

Enclosures: Child Protective Services Appeals and Fair Hearings
Summary of Investigation

5.16.2 Founded, parent,non-custodial parent or legal guardian

DATE

PARENT, NON-CUSTODIAL PARENT OR LEGAL GUARDIAN

ADDRESS

DRAFT

Dear **PARENT, NON-CUSTODIAL PARENT, LEGAL GUARDIAN**:

Thank you for your cooperation during the recent investigation. We are writing to inform you of the disposition of the investigation in which **CHILD(REN) NAMES** were listed as the alleged victim(s). The allegation(s) investigated pertained to **(C H O O S E A L L T H A T A P P L Y) PHYSICAL ABUSE; PHYSICAL NEGLECT; MEDICAL NEGLECT; SEXUAL ABUSE; MENTAL ABUSE/NEGLECT** by **ALLEGED ABUSER NAME**. After a thorough investigation of the facts and review with my supervisor, a disposition of founded, **LEVEL ONE , TWO, OR THREE** has been made. "Founded" means that a review of the facts shows by a preponderance of the evidence that child abuse or neglect has occurred. A level **ONE** includes those injuries/conditions, real or threatened, that result in or were likely to have resulted in serious harm to a child. **OR** A level **TWO** includes those injuries/conditions, real or threatened, that result in or were likely to have resulted in moderate harm to a child. **OR** A level **THREE** includes those injuries/conditions, real or threatened, that result in or were likely to have resulted in minimal harm to a child.

As a result of this disposition, the alleged abuser/neglector's name will be placed in the Virginia Child Abuse and Neglect Central Registry based on the level that was assessed.

CHOOSE ONE OF THE FOLLOWING:

For founded investigations, level one, names and records are kept for 18 years from the date of the complaint if there are no subsequent reports of child abuse/neglect regarding the same child(ren) or alleged abuser/neglector.

OR For founded investigations, level two, names and records are kept for 7 years from the date of the complaint if there are no subsequent reports of child abuse/neglect regarding the same child(ren) or alleged abuser/neglector.

OR For founded investigations, level three, names and records are kept for 3 years from the date of the complaint if there are no subsequent reports of child abuse/neglect regarding the same child(ren) or alleged abuser/neglector.

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OR (IF THE INVESTIGATION WAS SEXUAL ABUSE, LEVEL ONE)- For founded investigations, level one, names and records are kept for 18 years from the date of the complaint if there are no subsequent reports of child abuse/neglect regarding the same child(ren) or alleged abuser/neglector. Because this investigation involved serious sexual abuse of a child the investigation record shall be maintained by this agency for 25 years past the date of the complaint pursuant to §63.2-1514 A of the Code of Virginia; however, this retention time will not be reflected in the Central Registry past the purge date of 18 years.

Your child's name will be retained in the Central Registry for **30 days**. If you want your child's name to remain in the Central Registry for as long as the record of this investigation is retained, send a letter to:

Virginia Department of Social Services- CPS Unit

801 East Main Street

Richmond, Virginia 23219

Include your child(ren)'s name(s), date of birth, address and description of your relationship to the child.

If you have any questions or if this agency can be of further assistance, please contact me at **(_)_- __.**

Sincerely,

CPS WORKER NAME

CPS SUPERVISOR NAME

DRAFT

5.16.3 Unfounded, alleged abuser

DATE

ALLEGED ABUSER
ADDRESS

Dear **ALLEGED ABUSER**:

Thank you for your cooperation during the recent investigation. We are writing to inform you of the disposition of the investigation in which you were named as the alleged abuser/neglector. The report was made in reference to **CHILD(REN) NAMES**. The allegation(s) investigated pertained to **(CHOOSE ALL THAT APPLY) PHYSICAL ABUSE; PHYSICAL NEGLECT; MEDICAL NEGLECT; SEXUAL ABUSE; MENTAL ABUSE/NEGLECT**. As a review of the facts did not show a preponderance of evidence that abuse or neglect had occurred, we have made a disposition of unfounded. The person who made the report, if known, has been informed of this disposition.

Records of unfounded investigations are kept for *three years* from the date of the complaint if there are no subsequent reports of child abuse/neglect regarding the same child(ren) or alleged abuser/neglector pursuant to §63.2-1514 B of the Code of Virginia. You may request in writing to have the records of this investigation maintained for a period of time not to exceed two years pursuant to §63.2-1514 B of the Code of Virginia.

You have the right to petition the court to obtain the identity of the reporter if you believe the report was made in bad faith or maliciously pursuant to §63.2-1514 D of the Code of Virginia. If the court determines the report was made maliciously, you may present court documents to this agency and request all case records regarding this report be purged immediately.

IF THE INVESTIGATION WAS A CHILD FATALITY, ADD:

This investigation involved the death of a child, therefore, the record will be retained for the longer of 12 months or until the State Child Fatality Review Team has completed its review of the case pursuant to § 32.1-283.1 D of the Code of Virginia.

INCLUDE IF NEEDED:

Pursuant to §63.2-1503(N) of the Code of Virginia, we are required to notify the family advocacy representative of the United States Armed Forces if the investigation involved child(ren) of an active duty member of the United States Armed Forces or a member of their household.

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If you have any questions or if this agency can be of further assistance, please contact me at **(_)_- __.**

Sincerely,

CPS WORKER NAME
CPS SUPERVISOR NAME

5.16.4 Unfounded, parent, non-custdial parent or legal guardian

DATE

PARENT, NON-CUSTODIAL PARENT OR LEGAL GUARDIAN
ADDRESS

Dear **PARENT, NON-CUSTODIAL PARENT, LEGAL GUARDIAN**:

Thank you for your cooperation during the recent investigation. We are writing to inform you of the disposition of the investigation in which **CHILD(REN) NAMES** were listed as the alleged victim(s). The allegation(s) investigated pertained to **PHYSICAL ABUSE; PHYSICAL NEGLECT; MEDICAL NEGLECT; SEXUAL ABUSE; MENTAL ABUSE/NEGLECT** by **ALLEGED ABUSER/NEGLECTOR NAME.** As a review of the facts did not show a preponderance of evidence that abuse or neglect had occurred, we have made a disposition of unfounded.

Records of unfounded investigations are kept for *three years* from the date of the complaint if there are no subsequent reports of child abuse/neglect regarding the same child(ren) or alleged abuser/neglector pursuant to §63.2-1514 B of the Code of Virginia. The alleged abuser/neglector may request the record be maintained an additional year.

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IF THE INVESTIGATION WAS A CHILD FATALITY, ADD:

This investigation involved the death of a child, therefore, the record will be retained for the longer of 12 months or until the State Child Fatality Review Team has completed its review of the case pursuant to § 32.1-283.1 D of the Code of Virginia.

INCLUDE IF NEEDED:

Pursuant to §63.2-1503(N) of the Code of Virginia, we are required to notify the family advocacy representative of the United States Armed Forces if the investigation involved child(ren) of an active duty member of the United States Armed Forces or a member of their household.

If you have any questions or if this agency can be of further assistance, please contact me at **(_)_- __.**

Sincerely,

CPS WORKER NAME

CPS SUPERVISOR NAME

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5.17 Appendix E: Dispositional Assessments (sample template)

The following information is provided as an optional template for information that should be included in the dispositional assessment for a founded disposition.

5.17.1 State the date of supervisory staffing and names of participants.

Example: On January 1, 2016, this investigation was staffed for disposition and approved by CPS Supervisor Walter.

5.17.2 State the disposition regarding by whom to whom.

Example: The disposition of this investigation is founded for Physical Neglect (Inadequate Supervision) of Johnny Doe by his mother, Jane Doe.

5.17.3 Cite the specific regulatory definition for the type of abuse or neglect.

Example: Physical Neglect is defined in regulation: (22 VAC 40-705-30 B). Physical neglect occurs when there is the failure to provide food, clothing, shelter, or supervision for a child to the extent that the child's health or safety is endangered. This also includes abandonment and situations where the parent or caretaker's own incapacitating behavior or absence prevents or severely limits the performing of child caring tasks pursuant to § 63.2 –100 of the Code of Virginia. This also includes a child under the age of 18 whose parent or other person responsible for his care knowingly leaves the child alone in the same dwelling as a person, not related by blood or marriage, who has been convicted of an offense against a minor for which registration is required as a violent sexual offender pursuant to § 9.1-902. Additionally: (22 VAC 40-705-30 B1). Physical neglect may include multiple occurrences or a one-time critical or severe event that results in a threat to health or safety.

5.17.4 Summarize the evidence/facts that support the founded disposition.

It is NOT necessary to restate the entire investigation. Use a list or paragraph format. Be sure to include first source evidence.

Example: The following evidence does show by a preponderance of the evidence that this is founded:

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On December 10, 2015, two year old Johnny Smith was found by "LOCAL" law enforcement without any supervision in the car registered to Jane Doe in the parking lot of the "LOCAL" mall located at corner of Main and 8th Street.

According to the police report and statement of LOCAL law enforcement, the daycare provider, Jane Doe, did not arrive at the scene until 20 minutes after the police arrived and she stated that she had just run into the store to return an item. See full police report located in hard file.

The child, Johnny Smith, was examined by EMS and no further medical attention was required.

The daycare provider, Jane Doe stated to CPS worker that she had left the child in the car because he was asleep. She stated she had locked the doors and left the windows cracked open. She stated she did not think she was going to be gone for very long.

5.17.5 State the level for the founded disposition and cite the regulation.

Example: This was determined to be a level 2 finding for physical neglect (inadequate supervision). A level 2 is defined in regulation: (22 VAC 40-705-110). Level 2. This level includes those injuries/conditions, real or threatened, that result in or were likely to have resulted in moderate harm to a child.

5.17.6 Summarize the rationale for the assessed level.

Example: CPS guidance suggests that for neglect situations, a level 2 is indicated when "the child's minimal needs are sporadically met for food, clothing, shelter, supervision or medical care; or there is a pattern or one-time incident related to lack of supervision that caused or could have caused moderate harm". The rationale for assessing as level 2 includes that this was a one-time incident where a two year old child was without any supervision or care and while the child was not actually harmed, the potential for harm existed. This two year old child was unable to protect himself or make any decisions regarding his safety and well-being.

5.17.7 Other considerations.

When applicable add additional definitions and how the evidence supports the definition.

- Documentation- (required for certain findings such as emotional abuse)

Example: CPS guidance (Section 2.6.3 of the VDSS Child and Family Services Manual, Chapter C. July 2017) "when making a founded disposition of mental abuse or mental neglect, the CPS worker must obtain documentation supporting a nexus between the actions or inactions of the caretaker and the mental dysfunction demonstrated by the child or the threat of mental dysfunction." Ms. Eckstein, LCSW, stated in a letter to DSS dated 1-10-2016 that the victim child is exhibiting significant signs of post-traumatic stress syndrome due to the chronic exposure to domestic violence between the parents. See hard copy file for complete letter.

- Credibility- (suggested when the credibility of the child victim could be questioned)

Example: The victim child's statements about the incidences of sexual abuse were determined to be credible and believable due to the advanced level of details provided. Additionally, the child included in her disclosure that the alleged abuser told her this would be their "own private secret game" and that she should not tell anyone else about it.

- Caretaker- (particularly important to clarify if the role of caretaker is not obvious)

Example: Mr. Jones was determined to be a caretaker in this incident because not only did he reside in the family home; he was left in charge of the children on numerous occasions when the parents went to work.

- Jurisdiction- (important if there is any question as to where the abuse or neglect occurred, more important for criminal proceedings)

- Threat of Harm- If there is no actual injury, it is helpful to explain what a threat of harm constitutes. Remember, case law supports that an actual injury does not need to occur.

Example: The fight between the victim child and the involved caretaker included a time when the caretaker pointed a loaded gun at the victim child and said "everyone would be better off if they were just dead" however, it did not result in a physical injury. If the caretaker had followed through with pulling the trigger, the child could have died. This is considered threat of harm as defined in CPS guidance (Section 2.2 of the VDSS Child and Family Services Manual, Chapter C. October 2016) which states "The CPS

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worker must consider the circumstances surrounding the alleged act or omission by the caretaker influencing whether the child sustained an injury or whether there was a threat of an injury or of harm to the child. The evidence may establish circumstances that may create a threat of harm."

- Out of Family- Employees of Public Schools.

In addition to the required elements of a founded disposition, in all investigations involving public school employees, the local agency must document the evidence that supports that the employee acted with gross negligence or willful misconduct. These two elements are crucial when making a finding on any investigation that involves a school employee in the course of their employment. Local agencies must have detailed documentation that correlates the actions of the employee with injury or knowledge that the action will result in an injury.

Example: Ms. Smith, victim child's teacher, acted with gross negligence when she failed to provide proper supervision by allowing the five year old victim child to leave the rest of the class to go to the restroom alone, while on a field trip to the zoo. The victim child was found approximately thirty minutes later by security wandering around the zoo crying.

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CHILD DEATHS

TABLE OF CONTENTS

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6

CHILD DEATHS

6.1 Introduction

The investigation of child deaths is one of the most challenging and complex responsibilities of the child welfare system. The investigation of child deaths should be done through a multi-agency and multi-disciplinary process and conducted according to guidance and policy set forth in the VDSS Child and Family Services Manual Chapter C, Section 3: Complaints and Reports and Section 4: Assessments and Investigations. Additionally, if the fatality occurs in an Out-of-Family setting, the LDSS must complete the investigation in accordance with Section 5: Out-of-Family Investigations.

All child fatality cases *investigated by* CPS are reviewed at the regional level by the Child Fatality Review Team (CFRT). T*here is a CFRT for each region*.

6.2 Report a child death

The Virginia Administrative Code (VAC) requires the LDSS to contact the District Office of the Chief Medical Examiner, Commonwealth's Attorney, and local law enforcement when a report or complaint alleging abuse or neglect involves the death of a child.

6.2.1 Report child death to District Office of the Chief Medical Examiner

> (22 VAC 40-705-50 F1). When abuse or neglect is suspected in any case involving the death of a child, the local department shall report the case immediately to the regional medical examiner and local law-enforcement agency pursuant to § 63.2-1503 E of the Code of Virginia.

The LDSS shall **immediately** notify the District Office of the Chief Medical Examiner when the LDSS receives a complaint or report of abuse or neglect involving the death of a child. The LDSS should advise the Medical Examiner if the LDSS will be proceeding with an investigation and provide any preliminary information about the child and the caretakers to include any prior child welfare history. The *Family Services Specialist* shall document this notification in the *child welfare information system*.

The Family Services Specialist must request a written copy of the autopsy report ***within 5 working days*** *of notification to the District Office of the Chief Medical Examiner and document the request in the child welfare information system. See Appendix D: Sample Letter for a sample letter LDSS should utilize when providing the Medical Examiner's Office with notification of the child fatality and requesting a written copy of the autopsy report.*

6.2.2 Report child death to local Commonwealth's Attorney and law enforcement

> (22 VAC 40-705-50 F2). When abuse or neglect is suspected in any case involving the death of a child, the local department shall report the case immediately to the attorney for the Commonwealth and the local law-enforcement agency pursuant to § 63.2-1503 D of the Code of Virginia.

The LDSS shall **immediately** notify the local Commonwealth's Attorney and local law enforcement when the LDSS receives a complaint or report of suspected abuse or neglect involving the death of a child. The LDSS should advise the Commonwealth's Attorney and local law enforcement if the LDSS will be proceeding with an investigation and provide any preliminary information about the child and the caretakers. The *Family Services Specialist* shall document this notification in the child welfare information system.

6.2.3 Report child death to *CPS Practice Consultant*

> (22 VAC 40-705-50 F3). The local department shall contact the Department immediately upon receiving a complaint involving the death of a child and at the conclusion of the investigation.

The LDSS's *Family Services Supervisor* or supervisor's designee shall contact the *CPS Practice Consultant* **immediately** upon receiving a complaint involving the death of a child. *This includes the death or near-fatality of a child in foster care, even if the death or near-fatality occurs out-of-state or in another jurisdiction.* The *Family Services Specialist* shall document this notification in the child welfare information system.

The *CPS Practice Consultant* shall ensure the completion of the Preliminary Child Fatality/Near-Fatality Information Form and forward it to the CPS Program Manager **within *two working days*** of receipt of the information pertaining to the death of the child.

The CPS Program Manager shall inform the Commissioner's Office of the child death **within *two working days***. This information *may* also be shared with the State Board of Social Services.

6.2.4 Submit preliminary information concerning the child death

The LDSS shall provide the following preliminary information concerning the child death to the *CPS Practice Consultant* who will submit the information on the Child Fatality/Near-Fatality Information Form to the CPS Program Manager. The form can be found on the public website and in Appendix A.

The Preliminary Child Fatality/Near-Fatality Information Form provides initial or preliminary information about the child death and shall be completed with as much of the following information as possible.

6.2.4.1 Logistical information

- Name of LDSS.
- Name of investigating worker.
- Name of *Family Services Supervisor*.
- Date of complaint.
- Referral number.
- Person making the complaint.
- *CPS Practice Consultant*.

6.2.4.2 Demographic information

- Name of deceased child.
- Deceased child's date of birth.
- Date of child's death.
- Sex of child.
- Race of child.
- Type of alleged abuse/neglect.
- Name of alleged abuser/neglector.
- Relationship of alleged abuser/neglector to child.

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6.2.4.3 Reporting requirements

- Date reported to *CPS Practice Consultant*.
- Date reported to Commonwealth's Attorney.
- Date reported to law enforcement.
- Date reported to District Office of the Chief Medical Examiner.
- Date reported to CPS Program Manager.

6.2.4.4 Circumstances surrounding the child's death

- Detailed description of the child's death (when, where, why, how, who, and any related problems, including type of abuse/neglect).
- Information concerning the family's prior involvement with the LDSS (include a summary of prior reports and referral numbers).
- Information concerning the alleged perpetrator of the child's death (relationship to victim or other family members).
- Identification (including names and ages) of any siblings of the deceased child (requires conducting a safety assessment of any siblings of the deceased child and development of a Safety Plan, if safety decision is Conditionally Safe or Unsafe).

6.2.4.5 LDSS's plan of action

- Description of the LDSS's investigation plan.
- Description of the *CPS Practice Consultant*'s planned involvement and assistance.
- Date disposition is due.
- Any additional concerns or comments.

6.3 Investigation of child death

CPS has an integral role in the investigation regarding the victim child and family. Child death investigations have the best outcomes when there is timely notification and CPS and law enforcement conduct a joint investigation. The It is recommended that the LDSS use a MOU to ensure this notification and collaboration with law enforcement.

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When a CPS report involves a child death, the LDSS must meet ALL investigation requirements according to the CPS Guidance Manual. Refer to Section 3, Complaints and Reports and Section 4, Family Assessment and Investigation.

Additional resources regarding child fatality investigations can be found in Appendix C.

6.3.1 *CPS Practice Consultant* to provide technical assistance

The *CPS Practice Consultant* shall provide technical assistance to the LDSS throughout the investigation. The LDSS must consult with the *CPS Practice Consultant* prior to making the disposition and developing the service plan.

6.3.2 Assessing safety in a child fatality

CPS is responsible for determining the safety of any other children in the home. The safety assessment must be completed in all investigations involving the death of a child. Special safety considerations for the investigation of a child death includes:

- *Was a drug screen completed with the caretaker at the time of death?*
- *Was the caretaker impaired at the time of death?*
- *Was the child in a designated safe sleep space?*
- *Was the sleep space firm and free from blankets, pillows and objects?*
- *Was there any prior child welfare involvement with the family?*
- *Were there unsecured medication or weapons in the home?*
- *Was the victim child born substance-exposed?*

The safety assessment should include both the inside and outside home environment.

If there are other children in the home, the safety assessment will be either conditionally safe (requires a safety plan) or unsafe (requires a court order) as death of child will be *recorded* in safety factor #1 on the safety assessment tool. “Caretaker caused serious physical harm to the child and/or made a plausible threat to cause physical harm in the current Investigation/Family Assessment.”

If there are other children in the home under the age of two, the Family Services Specialist should provide the caretaker with written information and verbal education on safe sleep practices. The Family Services Specialist should document that safe

sleep information was provided to the caretaker in the child welfare information system.

6.3.3 Assessing risk in a child fatality

When assessing risk using the CPS Risk Assessment Tool, there is a policy override when the parent/caretaker action or inaction resulted in the death of a child due to abuse or neglect (previous or current). Policy overrides reflect seriousness and/or child vulnerability concerns, and have been determined by VDSS to warrant a risk level of very high regardless of the risk level indicated by the assessment tool. It is recommended to open a case if the risk is high or very high; however, if there are no other children in the home it is not necessary to provide CPS services.

6.3.4 Investigative protocol

Prior involvement with the child welfare system should be considered when determining the validity of the report as prior system involvement has been found to correlate with child deaths that are the result of abuse or neglect from a caretaker.

The validity determination of the CPS complaint regarding the fatality must be made prior to the response of the LDSS. The LDSS may not respond to the complaint/report of child abuse or neglect in order to determine the validity of the referral. Once the LDSS responds to a complaint or report of child abuse or neglect, the LDSS is responsible for ensuring the completion of an investigation.

Child death investigations have the best outcomes when there is timely notification and CPS and law enforcement conduct a joint investigation. The Investigating Infant and Child Death Cases protocol developed by the Department of Criminal Justice Services and the Child Death Case Reporting Tool can assist in the completion of a thorough investigation.

As part of a child death investigation, it is important to ask questions and obtain information to understand the circumstances surrounding the child's death. Some information can be obtained through the use of closed-ended questions but other information is best obtained through the use of open-ended inquiries that solicit narrative responses. The following is a list of suggested questions and inquiries that can be used to guide the investigation:

- *General Information*
    - *Demographics of the victim child and caretaker.*
    - *Who called 911?*
    - *Describe any first aid or emergency care given and who provided it.*

- *Who found the victim?*
- *When was the victim child last seen alive?*
- *When was the last feeding or meal for the victim child?*
- *What was the victim child's physical appearance at the time of death?*
- *What was the alleged abuser/neglector's and caretaker's demeanor at the time of death?*
- *Describe any prior child welfare involvement.*
- *What was the victim child's developmental level?*
- *What was the educational level of the victim child?*
- *What is the educational level of the alleged abuser/neglector and caretaker(s)?*
- *What is the criminal history of the alleged abuser/neglector and caretaker(s)?*

- *Physical Health*
  - *Describe any disabilities of victim child, alleged abuser/neglector, and caretaker(s).*
  - *Describe the victim child's health within the past 48 hours.*
  - *Describe the pregnancy and any complications.*
  - *Who provided prenatal care during the pregnancy?*
  - *What was the victim child's medical history?*
  - *Who was providing the victim child with medical care?*
  - *When was the last time the victim child received medical care?*
  - *Describe any medications being taken and/or prescribed and the name of the prescriber for the victim child, alleged abuser/neglector, or caretaker(s).*
  - *Describe any medical diagnoses for the victim child, alleged abuser/neglector, and caretaker(s).*

DRAFT

- *Mental Health*
    - *Describe any mental health diagnoses of the victim child, alleged abuser/neglector, and caretaker(s).*
    - *Describe any mental health treatment received by the victim child, alleged abuser/neglector, and caretaker(s).*
    - *Who is/was providing the mental health treatment services?*
    - *When did the victim child, alleged abuser/neglector, or caretaker last receive mental health treatment services?*
    - *Describe any psychotropic medications being prescribed and the name of the prescriber for the victim child, alleged abuser/neglector, or caretaker(s).*
- *Substance Use*
    - *Describe any substance use (illegal and legal) by the victim child, alleged abuser/neglector, and caretaker(s).*
    - *When was the substance (illegal and legal) last used and by whom?*
    - *Are there any substances (illegal and legal) in the home?*
- *Home Observations*
    - *Describe the temperature in the home.*
    - *Describe the functionality of the utilities in the home.*
    - *Describe the presence of food or formula in the home.*
    - *Describe any hazards noted inside or outside of the home.*
    - *Describe any notable odors inside or outside of the home.*
    - *Are there pets in the home?*
    - *Describe any pets in the home and their access to the victim child or siblings.*
    - *Describe the sleep space for all children and adults in the home.*
    - *What bedding is used for the sleep spaces in the home?*

DRAFT

- *Are there unsecured weapons in the home?*
- *Where are the weapons and ammunition stored in the home?*
- *Where are medications stored in the home?*

- *Siblings*
  - *Describe the educational and child care arrangements for the siblings in the home.*
  - *Where were the siblings when the victim child died?*
  - *When did the siblings last see the victim child alive?*
  - *When did the sibling last see the victim child eat or be fed?*
  - *Describe where the victim child slept in the home.*
  - *What do the siblings know about the victim child's death?*
  - *Describe the reaction of the siblings to the victim child's death.*
  - *Describe the victim child's relationship with the alleged abuser/neglector or caretaker(s).*
  - *How did the alleged abuser/neglector or caretaker(s) discipline the victim child?*

6.3.5 Death of a child in foster care

*If the child fatality involves a child in the custody of a LDSS, the LDSS Family Services Supervisor or Supervisor's designee must **immediately** notify the LDSS with legal custody of the child.*

*The LDSS Family Services Supervisor or Supervisor's designee must also **immediately** notify the CPS Practice Consultant and the Foster Care Practice Consultant. The Family Services Specialist must document these notifications in the child welfare information system. The LDSS should discuss potential conflicts of interest with their CPS Practice Consultant if the local department of jurisdiction is the custodian of the child in foster care or if the child is placed in a locally approved foster home approved by the local department of jurisdiction.*

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6.3.6 Child death case reporting tool

The purpose of the case reporting tool is to collect comprehensive information from multiple agencies that participate in the child fatality review. The form will document the circumstances involved in the death, investigative actions, services provided or needed, key risk factors, and actions recommended and/or taken by the regional child fatality review team. It collects critical information that is entered into the national database.

The CPS Practice Consultant will provide the LDSS with the case reporting tool from the National Center link and color-coded guide upon initial notification of a child death. The case reporting tool is also located on the public website. The data dictionary, which is located with the tool, provides definitions and question-by-question instructions that the Family Services Specialist should always refer to when completing the tool. This tool can assist the LDSS in completing a thorough investigation.

The Family Services Specialist should obtain detailed information and complete the sections as referenced in the color-coded guide, which can also be accessed and printed from FUSION. The Family Services Specialist should complete the information on the tool to the best of their ability throughout the investigation. If an attempt was made to find the answer but a sufficient answer could not be found, mark "U/K." If no attempt was made to find the answer, leave blank.

The completed case reporting tool must be submitted to the CPS Practice Consultant ***no later than five business days*** *after the completion of the investigation. The remaining sections of the case reporting tool will be completed at the regional child fatality review team meeting.*

6.3.7 Suspensions of child death investigations

The Code of Virginia § 63.2-1505 B5 grants exceptions to completing certain investigations under specific conditions. In any child death investigation which requires reports or records generated outside the local department in order to complete the investigation, such as an autopsy, the time needed to obtain these reports or records shall not be counted towards the 45 day timeframe to complete the investigation. These records must be necessary to complete the investigation and not available due to circumstances beyond the control of the local department. *The LDSS must submit a written request to the medical examiner to obtain a written copy of the autopsy report and document the request in the child welfare information system.* When the LDSS receives the reports or records, the 45 day timeframe resumes where it had left off, it does not start over.

The decision to suspend making a disposition within 45 days in these cases should be approved by a supervisor and documented in the child welfare information system.

If the LDSS has the evidence necessary to make the disposition they should not suspend the investigation.

As long as the investigation remains open, the LDSS retains all authorities and responsibilities of an investigation. The LDSS must document monthly updates in the child welfare information system until such time that the necessary reports or records to complete the investigation have been received.

The LDSS should notify the alleged abuser/neglector or involved caretakers and the alleged victim's parents or guardians when suspending an investigation. The notification to the alleged abuser/neglector or involved caretakers should include a brief explanation of the reason for the suspension. If written notification is made, a copy of the notification must be included in the LDSS's record and documented in the child welfare information system. If notification is made verbally, then the LDSS must document the notification in the child welfare information system. The LDSS must document the justification in the child welfare information system for the additional time needed to complete the investigation *and the monthly updates*.

6.3.8 Notify *CPS Practice Consultant* of disposition

The LDSS should consult with the CPS Practice Consultant prior to making the final disposition. The LDSS must notify the *CPS Practice Consultant* with the final disposition, assessed risk and any pending criminal charges or investigations concerning the child death. *The results of the autopsy must be documented in the child welfare information system.*

Each child death will be reviewed by a regional child fatality review team. The *CPS Practice Consultant* is responsible for scheduling the review of the child death with the regional child fatality review team.

> Pursuant to § 32.1-283.2C of the Code of Virginia, ….The review of a death shall be delayed until any criminal investigations connected with the death are completed or the Commonwealth consents to the commencement of such review prior to the completion of the criminal investigation.

6.4 Local, regional, and state child fatality reviews

The review of child deaths reported to Child Protective Services can best be achieved through a multi-agency, multi-disciplinary process that routinely and systematically examines circumstances surrounding the reported deaths of children.

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6.4.1 Local and regional child death review teams

The Code of Virginia authorizes reviews of child deaths at the local, regional, and/or state level.

(§ 32.1-283.2 of the Code of Virginia). Local and regional child fatality review teams established; membership; authority; confidentiality; immunity.

A. Upon the initiative of any local or regional law-enforcement agency, fire department, department of social services, emergency medical services agency, Commonwealth's attorney's office, or community services board, local or regional child fatality teams may be established for the purpose of conducting contemporaneous reviews of local child deaths in order to develop interventions and strategies for prevention specific to the locality or region. Each team shall establish rules and procedures to govern the review process. Agencies may share information but shall be bound by confidentiality and execute a sworn statement to honor the confidentiality of the information they share. Violations shall be punishable as a Class 3 misdemeanor. The State Child Fatality Review Team shall provide technical assistance and direction as provided for in subsection A of § 32.1-283.1.

B. Local and regional teams may be composed of the following persons from the localities represented on a particular board or their designees: a local or regional medical examiner, a local social services official in charge of child protective services, a director of the relevant local or district health department, a chief law-enforcement officer, a local fire marshal, *a local emergency medical services agency chief*, the attorney for the Commonwealth, an executive director of the local community services board or other local mental health agency, and such additional persons, not to exceed *four*, as may be appointed to serve by the chairperson of the local or regional team. The chairperson shall be elected from among the designated membership. The additional members appointed by the chairperson may include, but are not restricted to, representatives of local human services agencies; local public education agencies; local pediatricians, psychiatrists and psychologists; and local child advocacy organizations.

C. Each team shall establish local rules and procedures to govern the review process prior to conducting the first child fatality review. The review of a death shall be delayed until any criminal investigations connected with the death are completed or the Commonwealth consents to the commencement of such review prior to the completion of the criminal investigation.

D. All information and records obtained or created regarding the review of a fatality shall be confidential and shall be excluded from the Virginia Freedom of Information Act (§ 2.2-3700 et seq.) pursuant to subdivision 9 of § 2.2-3705.5. All such information and records shall be used by the team only in the exercise of its proper purpose and function and shall

DRAFT

not be disclosed. Such information or records shall not be subject to subpoena, subpoena duces tecum, or discovery or be admissible in any criminal or civil proceeding. If available from other sources, however, such information and records shall not be immune from subpoena, subpoena duces tecum, discovery or introduction into evidence when obtained through such other sources solely because the information and records were presented to the team during a fatality review. No person who participated in the reviews nor any member of the team shall be required to make any statement as to what transpired during the review or what information was collected during the review. Upon the conclusion of the fatality review, all information and records concerning the victim and the family shall be returned to the originating agency or destroyed. However, the findings of the team may be disclosed or published in statistical or other form which shall not identify individuals. The portions of meetings in which individual cases are discussed by the team shall be closed pursuant to subdivision A 21 of § 2.2-3711. All team members, persons attending closed team meetings, and persons presenting information and records on specific fatalities to the team during closed meetings shall execute a sworn statement to honor the confidentiality of the information, records, discussions, and opinions disclosed during any closed meeting to review a specific death. Violations of this subsection shall be punishable as a Class 3 misdemeanor.

E. Members of teams, as well as their agents and employees, shall be immune from civil liability for any act or omission made in connection with participation in a child fatality review team review, unless such act or omission was the result of gross negligence or willful misconduct. Any organization, institution, or person furnishing information, data, testimony, reports or records to review teams as part of such review, shall be immune from civil liability for any act or omission in furnishing such information, unless such act or omission was the result of gross negligence or willful misconduct.

6.4.2 Regional Child Fatality Review Teams

All child fatalities will be reviewed by the regional child fatality review team *for each respective jurisdiction*. The regional child fatality review team will examine the circumstances of *each* child's death.

6.4.2.1 Purpose of child fatality review

The purpose of a fatality review is:

- Conduct comprehensive multidisciplinary reviews.
- Better understand how and why children die.
- Improve child death investigations.

- Improve the systematic response to children in need.
- Use the findings to take action to prevent other deaths.
- Improve the health and safety of children.

6.4.2.2 Role and responsibilities of CPS

CPS is responsible for investigating the allegations of abuse or neglect and recommending services to children and families. CPS also serves as a liaison to other community resources. The *Family Services Specialist or current Family Services Supervisor* is responsible for providing vital information to the child review team to include:

- The case status.
- A summary of the investigation.
- Family and child history and socioeconomic factors such as employment, marital status, previous deaths, history of intimate partner violence, and history of substance abuse or mental illness.
- Prior CPS involvement.

The *Family Services Specialist* will be notified by phone or in writing by the *CPS Practice Consultant* as to the date, time and location of the Regional Fatality Review meeting. The notification must include the child's initials, locality, date of birth, and date of death and referral number. In order to preserve confidentiality, e-mails should not include identifying information such as names. Prior to the meeting, the *Family Services Specialist* should complete all documentation in the child welfare information system and all supervisory approvals should be done.

6.4.2.3 Presenting a case for the regional child fatality review meeting

The *Family Services Specialist*, *Family Services Supervisor,* or the person who will present the case at the review meeting, *should* be prepared to verbally present *a summary which includes* the investigative details of the case. The following is a list of suggested questions that can be used as a guide for the verbal presentation:

- How was the agency notified of the fatality?
- What were the circumstances of the death? How was the injury described and explained? What was the supervision of the child? Were other persons present and what did they report?

- What was the agency's initial response? Who responded and when? What was happening upon arrival? What were the responses of those present? Who was interviewed? What did they say? What was observed?
- Was the child or family known to DSS? If so, how?
- Were there any prior family assessments or investigations? What did they involve? W*hat was the outcome and risk level?* What were the outcomes of those interventions?
- What safety factors and protective capacities were identified? What risk factors were identified?
- What services have been provided to the family before and after the fatality?
- *Did CPS and law enforcement conduct a joint investigation of the child death?*

The presenter *must* bring a copy of the case record, including any photographs.

Maintaining confidentiality is extremely important. The *Family Services Specialist*, *Family Services Supervisor*, or presenter will be asked to sign a confidentiality form at the review meeting. Section § 32.1-283.2 of the Code of Virginia pertains to confidentiality:

> (§ 32.1-283.2 of the Code of Virginia). D. All information and records obtained or created regarding the review of a fatality shall be confidential and shall be excluded from the Virginia Freedom of Information Act (§ 2.2-3700 et seq.) pursuant to subdivision 9 of § 2.2-3705.5. All such information and records shall be used by the team only in the exercise of its proper purpose and function and shall not be disclosed…. The portions of meetings in which individual cases are discussed by the team shall be closed pursuant to subdivision A 21 of § 2.2-3711. All team members, persons attending closed team meetings, and persons presenting information and records on specific fatalities to the team during closed meetings shall execute a sworn statement to honor the confidentiality of the information, records, discussions, and opinions disclosed during any closed meeting to review a specific death. Violations of this subsection shall be punishable as a Class 3 misdemeanor.

The completed case reporting tool must be submitted to the CPS Practice Consultant ***no later than five business days*** *after the completion of the investigation.* The remaining sections of the case reporting tool will be completed

at the regional child fatality review team meeting. The final completed tool will be entered into the National MCH Center for Child Death Review database.

For additional information on what to expect at a child fatality review team and a tip sheet for presenters please see Appendix C. For additional information regarding the roles of all key professionals on child fatality review teams *please review the job aid on FUSION*.

6.4.2.4 Regional child fatality review prevention initiatives

The Regional Child Fatality Review Teams will be asked to report to the CPS Program Manager on an annual basis, describing significant findings and themes from the reviews as well as any recommendations or initiatives as a result of the team's discussion of that year's child death cases. These may include actions in the recommended, planning or implementation stage. These actions may be short or long term. These actions may be at the local, state, or national level. Some examples of actions may include conducting media campaigns, having public forums, revising policy, providing training, implementing new programs, or enacting new laws.

6.4.3 State Child Fatality Review Team

The Code of Virginia established a statewide team to analyze child deaths in a systematic way. This includes child deaths due to abuse or neglect as well as child deaths due to other causes.

> (§ 32.1-283.1 of the Code of Virginia). State Child Fatality Review Team established; membership; access to and maintenance of records; confidentiality; etc.
>
> A. There is hereby created the State Child Fatality Review Team, hereinafter referred to as the "Team," which shall develop and implement procedures to ensure that child deaths occurring in Virginia are analyzed in a systematic way. The Team shall review (i) violent and unnatural child deaths, (ii) sudden child deaths occurring within the first 18 months of life, and (iii) those fatalities for which the cause or manner of death was not determined with reasonable medical certainty. No child death review shall be initiated by the Team until conclusion of any law-enforcement investigation or criminal prosecution. The Team shall (i) develop and revise as necessary operating procedures for the review of child deaths, including identification of cases to be reviewed and procedures for coordination among the agencies and professionals involved, (ii) improve the identification, data collection, and record keeping of the causes of child death, (iii) recommend components for prevention and education programs, (iv) recommend training to improve the investigation of child deaths, and (v) provide technical assistance, upon request, to any local child fatality teams that may be established. The operating procedures for the review

DRAFT

of child deaths shall be exempt from the Administrative Process Act (§ 2.2-4000 et seq.) pursuant to subdivision 17 of subsection B of § 2.2-4002.

6.5 Release of child fatality or near fatality information

There are specific requirements related to the release of information in child deaths. The general discussion of laws and regulations regarding confidentiality and disclosure of information are discussed in Section 9: Confidentiality of this manual. The VAC requires the VDSS to develop guidelines allowing for public disclosure in instances of a child death.

(22 VAC 40-705-160 A6). Pursuant to the Child Abuse Prevention and Treatment Act, as amended (42 USC § 5101 et seq.), the department shall develop guidelines to allow for public disclosure in instances of child fatality or near fatality.

6.5.1 Guidelines for release of information in a child fatality or near fatality

The VAC establishes the information that can be released in child abuse or neglect cases with a child death.

(22 VAC 40-910-100 B). Releasing confidential social services information.

3. b. Child Protective Services Client Records and Information Disclosure:

(1) Child protective services client records can be released to persons having a legitimate interest pursuant to § 63.2-105 A of the Code of Virginia.

(2) The public has a legitimate interest to limited information about child abuse or neglect cases that resulted in a child fatality or near fatality. Pursuant to the Child Abuse and Prevention Treatment Act (CAPTA), as amended (P.L. 108-36(42 USC §5106a)) states must have provisions that allow for public disclosure of the findings or information about the case of child abuse or neglect that has resulted in a child fatality or near fatality. Accordingly, agencies must release the following information to the public, providing that nothing disclosed would be likely to endanger the life, safety, or physical or emotional well-being of a child or the life or safety of any other person; or that may compromise the integrity of a Child Protective Services investigation, or a civil or criminal investigation, or judicial proceeding:

(a) The fact that a report has been made concerning the alleged victim child or other children living in the same household;

(b) Whether an investigation has been initiated;

DRAFT

(c) The result of the completed investigation;

(d) Whether previous reports have been made concerning the alleged victim child or other children living in the same household and the dates thereof, a summary of those previous reports, and the dates and outcome of any investigations or actions taken by the agency in response to those previous reports of child abuse or neglect;

(e) The agency's activities in handling the case.

6.5.2 Investigation of child death by Children's Ombudsman

Pursuant to § 2.2-443 B of the Code of Virginia, the Children's Ombudsman may investigate all child fatality cases that occurred or are alleged to have occurred due to child abuse or child neglect in the following situations:

- *A child died during an active child protective services investigation or open services case, or there was a valid or invalid child protective services complaint within 12 months immediately preceding the child's death.*
- *A child died while in foster care, unless the death is determined to have resulted from natural causes and there were no prior child protective services or licensing complaints concerning the foster home.*
- *A child was returned home from foster care and there is an active foster care case.*
- *A foster care case involving the deceased child or sibling was closed within 24 months immediately preceding the child's death.*

In order to assist the Children's Ombudsman with their investigation of a child fatality, the LDSS must follow the guidance in 9.2.10, Release information to Office of Children's Ombudsman.

6.5.3 Exceptions for release of information in a child death

Pursuant to § 32.1-283.1 C of the Code of Virginia, information gathered at local, regional or state child fatality review is exempt from being released. These teams can publish information in statistical or other forms that do not identify the individual decedent.

6.6 Retention of CPS report involving a child death

The Code of Virginia § 32.1-283.1 D requires the records of all reports involving a child death to be retained until the State Child Fatality Review Team has had an opportunity to review them. The reports to be retained include screened out reports and founded and unfounded investigations. The LDSS may contact the *CPS Practice Consultant* if there is any question about retention of a specific record. *The LDSS must document that a child death occurred in the child welfare information system so the record is not purged prematurely.*

DRAFT

6.7 Appendix A: Preliminary Child Fatality/Near-Fatality Information Form

The Preliminary Child Fatality/Near-Fatality Information Form provides initial or preliminary information and shall be completed with as much of the following information as possible:

CAPTA (Child Abuse Prevention and Treatment Act) defines a "near fatality" as an act that, as certified by a physician, places the child in serious or critical condition

(22VAC40-705-10) "Life-threatening condition" means a condition that if left untreated, more likely than not will result in death and for which the recommended medical treatments carry a probable chance of impairing the health of the individual or a risk of terminating the life of the individual.

A near-fatality requires that a physician certify that a child is in serious or critical condition at the time of the report. Such certification can be either in writing or verbal. Hospital records which indicate the child's condition is serious or critical and life threatening are sufficient. The physician certification must be documented in the child welfare information system.

Referral #: Date of Complaint:

LDSS:	
Investigating Worker:	Phone:
Family Services Supervisor:	Phone:
Person Making Complaint:	

Section A: Referral Information

Name of Child:			
Child's Date of Birth:	Date of Child's Death/Significant Event:		
Sex of Child: ☐ Male ☐ Female ☐ Unknown	Race: ☐ White ☐ Black ☐ Asian ☐ Multi-Racial ☐ Unknown		
Type of Alleged Abuse or Neglect: ☐ Physical Neglect ☐ Medical Neglect ☐ Physical Abuse ☐ Sexual Abuse ☐ Mental Abuse/Neglect			
Name of Alleged Abuser/Neglector:			
Relationship of Alleged Abuser / Neglector to Child:	☐ Mother ☐ Father ☐ Parents ☐ Grandmother ☐ Other	☐ Grandfather ☐ Foster Parent ☐ Uncle ☐ Aunt ☐ Child Care Worker	☐ Siblings ☐ Stepparent ☐ Father's Paramour ☐ Mother's Paramour ☐ Child Care Worker

		(reg)	(unreg)
Name of second abuser:			
Relationship of 2nd Abuser to Child (if applicable):			

Section B: Reporting Requirements

CPS Regional Specialist:	Date Reported:
VDSS CPS Program Manager:	Date Reported:
Law Enforcement:	Date Reported:
Commonwealth's Attorney:	Date Reported:
Regional Medical Examiner:	Date Reported:

Section C: Circumstances Surrounding the Child's Death/Significant Event

Detailed Description of the Child's Death/Significant Event (When, where, why, how, who, and any related problems.)

Family's Prior Involvement with the LDSS:

Program
CPS Case/Referral: Summary of Involvement:
Benefits Case/Referral: Summary of Involvement:
FC/Adoption Case/Referral: Summary of Involvement:

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Other:

Siblings of the (Victim) Child – (Requires conducting a safety assessment of any siblings of the victim child and development of a safety plan, if safety decision is conditionally safe or unsafe):

Sibling Name	DOB	Race	Sex	Initial Safety Decision, please choose from: "safe", "conditionally safe", or "unsafe"
Safety Plan Summary:				

LDSS Action Plan (describe Investigation Plan; Regional Specialist's planned involvement and assistance; and any additional comments and concerns.

Disposition Due Date:

Update/Addendum:

DRAFT

6.8 Appendix B: Near Child Fatalities

The Child Abuse and Prevention Treatment Act requires tracking and public disclosure of cases of child abuse or neglect that result in a near-fatalities. The examination of the circumstances surrounding near fatalities assist in the identification of child protection issues and improve efforts to prevent future child fatalities and near fatalities. See Section 3.7 Report Child Fatalities and Near Fatalities for additional information.

6.8.1 Definition of "near fatality"

The Child Abuse and Prevention Treatment Act (CAPTA) defines a "near fatality" as an act that, as certified by a physician, places the child in serious or critical condition. The VAC provides the following definitions:

> (22VAC40-705-10) "Near fatality" means an act that, as certified by a physician, places the child in serious or critical condition. Serious or critical condition is a life-threatening condition or injury.
>
> (22VAC40-705-10) "Life-threatening condition" means a condition that if left untreated more likely than not will result in death and for which the recommended medical treatments carry a probable chance of impairing the health of the individual or a risk of terminating the life of the individual.

Inherent within the definition of a near fatality is the requirement that a physician certify that the child is in serious or critical condition at the time of the report. Certification by a physician can be either in writing or verbal. Hospital records which indicate the child's condition is serious or critical and life threatening are sufficient. The physician certification must be documented in the child welfare information system. However, "near fatality" is a phrase used in child protective services. It is not a medical term.

6.8.2 Documentation and notification of near fatalities

The LDSS must document situations which constitute a near fatality of a child in the child welfare information system. The type of abuse or neglect believed to have caused the near fatality must be documented in the child welfare information system. The LDSS must inform the *CPS Practice Consultant* as soon as possible of all situations which constitute a near fatality and document the notification in the child welfare information system. The *CPS Practice Consultant* must ensure the completion of the Preliminary Child Fatality/Near-Fatality Information Form. The form can be found on the public website and in Appendix A. The *CPS Practice Consultant* must forward the Preliminary Child Fatality/Near-Fatality Information Form to the CPS Program Manager and Child Fatality Specialist as soon as possible.

Child maltreatment deaths may involve a delay between the time the child is determined to be in critical or serious condition and the subsequent death of the child. If during the course of the investigation the child dies, the child welfare information system must be changed to reflect the fatality. A child cannot be considered a near fatality and a fatality in the child welfare information system.

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6.9 Appendix C: Additional Resources for Child Fatalities

The internet is abundant with information relating to child fatalities, child fatality review and investigations of child deaths. The following resources may assist the local *Family Services Specialist* in the investigation of a child fatality.

6.9.1 American Academy of Pediatrics

The American Academy of Pediatrics Professional Journal, Pediatrics, provides expert research and information on a variety of topics. The following articles may be useful to the LDSS staff:

Improvements in Infant Sleep Position: We Can Do Better!

The National Center for Fatality Review and Prevention SIDS/SUID Fact Sheet

6.9.2 The National Center for the Review and Prevention of Child Death

The National Center for the Review and Prevention of Child Death is a resource center for state and local CDR programs, funded by the Maternal and Child Health Bureau. It promotes supports and enhances child death review methodology and activities at the state, community and national levels.

6.9.3 Center for Disease Control and Prevention

The *Center for Disease Control and Prevention is a resource for information on* Sudden Unexpected Infant Death (SUID).

6.9.4 Investigating child fatalities

The Office of Juvenile Justice and Delinquency Prevention publishes a portable guide which presents practical information on the circumstances that point to the willful, rather than accidental, injury or death of an infant or child and the evidence required to prove it, as well as the techniques for obtaining such evidence. It is entitled Battered Child Syndrome: Investigating Physical Abuse and Homicide.

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6.10 Appendix D: *Sample Letter*

6.10.1 Notification to Medical Examiner

The following letter can be used to provide notification of a child death and to request a written copy of the autopsy report.

Month, Date, Year

Department of Health

Office of Chief Medical Examiner

Street Address

City, VA Zip

In Re: Victim Child

DOB: 2 digits/2 digits/4 digits

Parent: First/Last Name and First/Last Name

Resident at time of death:

Street Address

City, VA Zip

Dear Office of Chief Medical Examiner:

I am writing to provide notification of the death of above referenced child pursuant to §63.2-1503 E of the Code of Virginia. The date of death is 2 digits/2 digits/4 digits.

I am a Family Services Specialist at insert agency name and I have been assigned the death investigation of the victim child reference above. As part of the death investigation, the insert agency name Department of Social Services requests a written copy of the completed autopsy report. Please forward the information to:

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- *insert agency name Department of Social Services,*
- *Attention: Assigned Worker Name, Family Services Specialist*
- *Street Address*
- *City, VA Zip.*

If you have any questions, I may be reached at xxx-xxx-xxxx. Thank you for your immediate attention in this matter.

Sincerely,

Worker Name

Family Services Specialist

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9

CONFIDENTIALITY

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TABLE OF CONTENTS

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DRAFT

9

CONFIDENTIALITY

9.1 Introduction

It is the policy of the Commonwealth to promote ready access to records in the custody of public officials and free entry to meetings of public bodies wherein the business of the Commonwealth is being conducted. The purpose for promoting open disclosure of the activities of state government is to foster an increased awareness by all persons of governmental activities and afford every opportunity to citizens to witness the operations of government. To ensure the open disclosure of public documents, the Virginia Freedom of Information Act (FOIA) provides for the release of information that is not protected by Federal law, Code of Virginia or Virginia Administrative Code (VAC) provisions for maintaining confidentiality.[1]

In performing its statutory duties, such as conducting an investigation of a report of alleged child abuse or maintaining the central registry, the Department (VDSS) and the local department of social services (LDSS) will collect and maintain personal information about an individual. Having recognized that the extensive collection, maintenance, use and dissemination of personal information directly affect an individual's rights concerning privacy, the Code of Virginia authorizes the release of certain information under the Government Data Collection and Dissemination Practices Act.[2] The Virginia FOIA (Code of Virginia § 2.2-3700 et seq.) provides a person access to records in the custody of public

[1] The Virginia Freedom of Information Act provides the statutory authority for the release of information between public agencies and the public. Please see Code of Virginia § 2.2-3700 B.

[2] Code of Virginia § 2.2-3800 B and C.

officials. The provisions of the Virginia FOIA and the Government Data Collection and Dissemination Practices Act apply to the VDSS and to the LDSS.

When the LDSS receives a request for information, the LDSS must determine whether the information requested is confidential and must be protected, or whether the information requested should be released under the Virginia FOIA, the Government Data Collection and Dissemination Practices Act or VAC provision. Given the sensitive nature of a CPS investigation, the LDSS must ensure that the release of information does not violate any Federal law, Code of Virginia, or VAC provisions.

In all instances of requests for release of information, LDSS are strongly encouraged to seek legal advice and counsel prior to responding to a request the release of information under the Virginia Freedom of Information Act, the Government Data Collection and Dissemination Practices Act, or any other Code of Virginia provision.

9.2 Mandatory release of information

The Code of Virginia and the VAC mandate the release of information to specific parties under certain circumstances:

> (22 VAC 40-705-160 A). In the following instances of mandatory disclosure the local department shall release child protective services information. The local department may do so without any written release.

9.2.1 Report Information to Commonwealth's Attorney and law enforcement

Code of Virginia § 63.2-1503 D requires the LDSS to report certain cases of abuse and neglect to the local Commonwealth's Attorney and to law enforcement.

> (22 VAC 40-705-160 A1). Report to attorney for the Commonwealth and law enforcement pursuant to § 63.2-1503 D of the Code of Virginia.

9.2.1.1 Complaints or reports that LDSS shall report to Commonwealth's Attorney and law enforcement

The LDSS shall contact the local attorney for the Commonwealth and law enforcement when a report or complaint is received alleging abuse or neglect involving:

- The death of a child;

- An injury or threatened injury to the child in which a felony or Class 1 misdemeanor is also suspected;
- Any sexual abuse, suspected sexual abuse or other sexual offense involving a child, including the use or display of the child in sexually explicit visual material, as defined in § 18.2-374.1;
- Any abduction of a child;
- Any felony or Class 1 misdemeanor drug offense involving a child; or
- Contributing to the delinquency of a minor in violation of § 18.2-371.

9.2.1.2 Information to be provided to Commonwealth's Attorney and law enforcement

The LDSS shall provide the local attorney for the Commonwealth and the local law enforcement agency with records of any complaints of abuse or neglect involving the victim or the alleged perpetrator.

The LDSS cannot allow reports of the death of the victim from other local agencies to substitute for direct reports to the attorney for the Commonwealth and the local law-enforcement agency.

The LDSS shall make available all information upon which the report is based including the name of the complainant and the records of any complaint of abuse or neglect involving the victim or the alleged perpetrator.

9.2.1.3 Complaints or reports involving violent sexual offenders that LDSS shall report to Commonwealth's Attorney

> (§ 63.2-1503 D). The local department shall notify the local attorney for the Commonwealth of all complaints of suspected child abuse or neglect involving the child's being left alone in the same dwelling with a person to whom the child is not related by blood or marriage and who has been convicted of an offense against a minor for which registration is required as a violent sexual offender pursuant to § 9.1-902, immediately, but in no case more than two hours of receipt of the complaint, and shall provide the attorney for the Commonwealth with records and information of the local department that would help determine whether a violation of post-release

> conditions, probation, parole, or court order has occurred due to the nonrelative sexual offender's contact with the child.

All complaints or reports involving a child being left alone in the same dwelling with a violent sexual offender who is not related to the child by blood or marriage must be reported to the local attorney for the Commonwealth immediately but not longer than two (2) hours of receipt of the complaint or report.

The LDSS shall provide records and information to the local attorney for the Commonwealth that would help determine whether a violation of post-release conditions, probation, parole, or court order has occurred due to the nonrelative sexual offender's contact with the child.

The LDSS must document the date and time of notification to the local attorney for the Commonwealth in the child welfare information system. This notification should be documented on the referral acceptance screen and in the referral as an Interview and Interaction (I and I). The LDSS may use the Notification to Law Enforcement form which has been updated to include complaints and reports involving violent sexual offenders. The form is located in Section 3, Appendix C and is also available on the public VDSS website under forms.

9.2.2 Report information to regional medical examiner's office

Code of Virginia § 63.2-1503 E requires the LDSS to report certain cases of abuse and neglect to the regional medical examiner's office. The VAC restates that requirement.

> (22 VAC 40-705-160 A2). Report to the regional medical examiner's office pursuant to § 63.2-1503 E of the Code of Virginia.

The LDSS should also advise the regional medical examiner's office if the report or complaint was accepted and if an investigation will be conducted.

9.2.3 Court mandated disclosure

The LDSS cannot disregard a court order for the release of information. If the LDSS believes the disclosure is inappropriate, it may contest the request for information through legal counsel. If, after hearing the LDSS's arguments to maintain the confidentiality of the Child Protective Services (CPS) information, the court still orders

the information to be released, the LDSS shall comply. LDSS are encouraged to seek advice from the agency's legal counsel in these matters.

9.2.4 Release of certain information to the complainant

> (22 VAC 40-705-140 D). Complainant.
> 1. When an unfounded disposition is made, the child protective services worker shall notify the complainant, when known, in writing that the complaint was investigated and determined to be unfounded. The worker shall file a copy in the case record.
> 2. When a founded disposition is made, the child protective services worker shall notify the complainant, when known, in writing that the complaint was investigated and necessary action was taken. The local worker shall file a copy in the case record.
> 3. When a family assessment is completed, the child protective services worker shall notify the complainant, when known, that the complaint was assessed and necessary action taken.

Generally, the information released to the complainant pertains to whether the complaint or report was unfounded or the LDSS took necessary action. Disclosing information to a complainant is limited to the procedures for notification of the disposition required by the VAC and this guidance manual, except as may otherwise apply under required or discretionary disclosure in this section.

9.2.5 Release of information to military Family Advocacy Program

> (§ 63.2-1503 N of the Code of Virginia) Notwithstanding any other provision of law, the local department, in accordance with Board regulations, shall transmit information regarding reports, complaints, family assessments, and investigations involving children of active duty members of the United States Armed Forces or members of their household to family advocacy representatives of the United States Armed Forces.

Effective July 1, 2017, all reports involving a dependent child of an active duty military member or a member of his household shall be reported to the Military Family Advocacy Program. This includes invalid complaints or reports, founded and unfounded investigations and family assessments.

The VAC defines Family Advocacy Program representative:

> (22 VAC 40-705-10). "Family Advocacy Program representative" means the professional employed by the United States Armed Forces who has responsibility for the program designed to address prevention, identification, evaluation, treatment, rehabilitation, follow-up and reporting of family violence, pursuant to 22 VAC 40-705-140.

The VAC also provides the LDSS with the authority to release information, when appropriate, to a representative of the Family Advocacy Program when it is in the best interest of the child.

> (22 VAC 40-705-140 E). 4. When needed by the Family Advocacy Program representative to facilitate treatment and service provision to the military family, any other additional information not prohibited from being released by state or federal law or regulation shall also be provided to the Family Advocacy Program representative when the local department determines such release to be in the best interest of the child.

9.2.6 Release information to Department of Child Support Enforcement

> (22 VAC 40-705-160 A9). Child protective services shall, on request by the Division of Child Support Enforcement, supply information pursuant to § 63.2-103 of the Code of Virginia.

9.2.7 Provide information to citizen review panels

The Child Abuse Prevention and Treatment Act (CAPTA), as amended (42 USC § 5101 et seq.), requires case-specific information about child abuse and neglect reports and investigations be disclosed to citizen review panels, when requested. The VAC addresses the CAPTA requirement:

> (22 VAC 40-705-160 A5). Pursuant to the Child Abuse Prevention and Treatment Act, as amended (42 USC § 5101 et seq.), and federal regulations (45 CFR § 1340), the local department shall provide case-specific information about child abuse and neglect reports and investigations to citizen review panels when requested.

CAPTA §106(b)(2)(v)(iii) requires the establishment of not less than three (3) citizen review panels. Any release of information to citizen review panels shall be in accordance with the confidentiality provisions of this chapter. §§ 63.2-104 and 63.2-105 of the Code of Virginia provide the foundation for the disclosure of findings or information about a case of child abuse or neglect.

9.2.7.1 Children's Justice Act/Court Appointed Special Advocate Advisory Committee (CJA/CASA)

The major purpose of the advisory committee to the Court Appointed Special Advocate (CASA) Program is to advise the Criminal Justice Board on all matters relating to the CASA Program and the needs of clients served by the program.

The fifteen members are knowledgeable of court matters, child welfare, and juvenile justice issues and representatives of state and local interests.

9.2.7.2 The Child Abuse and Neglect Committee of the Family and Children's Trust Fund (FACT)

Code of Virginia § 63.2-2100 establishes the Family and Children's Trust Fund (FACT) which was created as a public-private partnership to address family violence through improved prevention and treatment efforts and increased public awareness. FACT is overseen by a Board of Trustees who are appointed by the Governor and meets at least quarterly. FACT raises and distributes funds that support local community programs and statewide public awareness projects, and through its Child Abuse and Neglect Committee they advise the VDSS, Board of Social Services, and the Governor on matters concerning programs for the treatment and prevention of abused and neglected children and their families.

9.2.7.3 State Child Fatality Review Team

Code of Virginia § 32.1-283.1 establishes the State Child Fatality Review Team to develop and implement procedures to ensure that child deaths occurring in Virginia are analyzed in a systematic way (see Section 11 Child Deaths).

9.2.8 Release information to Court Appointed Special Advocate

> (22 VAC 40-705-160 A10). The local department shall release child protective services information to a court appointed special advocate pursuant to § 9.1-156 A of the Code of Virginia.

Code of Virginia § 9.1-151 establishes the CASA Program administered by the Department of Criminal Justice Services. The program provides services to children who are subjects of judicial proceedings involving allegations that the child is abused, neglected, in need of services or in need of supervision. Code of Virginia § 9.1-156 provides that, upon presentation by a court appointed special advocate of the order of his appointment and upon specific court order, the LDSS shall permit the advocate to inspect and copy any records relating to the child involved in the court case.

9.2.9 Release information to guardian ad litem

> (22 VAC 40-705-160 A11). The local department shall release child protective services information to a court appointed guardian ad litem pursuant to § 16.1-266 G of the Code of Virginia.

Code of Virginia § 16.1-266 provides that a guardian ad litem shall be appointed by a court before the commencement of any court proceeding involving a child who is alleged to be abused or neglected. One of the purposes of appointing a guardian ad litem is to obtain first-hand, a clear understanding of the situation and needs of the child. Upon presentation by a guardian ad litem of the court order of his appointment and upon specific court order, the LDSS shall permit the guardian ad litem to inspect and copy any records relating to the child involved in the court case.

9.2.10 Release information to Office of Children's Ombudsman

The Office of the Children's Ombudsman was established in § 2.2-439 of the Code of Virginia to effect changes in policy, procedure, and legislation; educate the public; investigate and review actions of the Department, local departments, child-placing agencies, or child-caring institutions; and monitor and ensure compliance with relevant statutes, rules, and policies pertaining to child protective services and the placement, supervision, and treatment of, and improvement of delivery of care to, children in foster care and adoptive homes.

Pursuant to § 2.2-445 of the Code of Virginia, the Department or LDSS shall do the following:

- *Upon the Ombudsman's request, grant the Ombudsman or the Ombudsman's designee access to all information, records, and documents in the possession of the Department or local department or child-placing agency that the Ombudsman considers relevant and necessary in an investigation.*
- *Assist the Ombudsman to obtain the necessary releases of those documents that are specifically restricted.*
- *Upon the Ombudsman's request, provide the Ombudsman with progress reports concerning the administrative processing of a complaint.*
- *Upon the Ombudsman's request, provide the Ombudsman the information requested under subdivision 1 or notification within 10 business days after the request that the Department or local department has determined that release of the information would violate federal or state law.*

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9.3 Discretionary release of information

In some instances, disclosure of information in a CPS case record by the LDSS will be mandated. In other instances, disclosure of certain information will be prohibited or limited.

This section addresses the discretionary release of information from a CPS case record by the LDSS. Code of Virginia §§ 63.2-104 and 63.2-105 provide the statutory framework for collecting and maintaining information gathered during a CPS investigation and related proceedings and for the release of such information and to whom it may be released.

In all instances of requests for release of information, LDSS are strongly encouraged to seek legal advice and counsel prior to responding to the request.

When an LDSS exercises its discretion to release confidential information to any person who meets one or more of the criteria set forth, the LDSS shall be presumed to have exercised its discretion in a reasonable and lawful manner as noted in Code of Virginia § 63.2-105.

9.3.1 Burden on LDSS to ensure the proper release of information

Any time the LDSS does release information contained in a CPS investigative record, the LDSS must ensure that the release of information is proper and consistent with Federal law, the Code of Virginia, and the VAC. The VAC emphasizes the need for the LDSS to ensure the confidentiality of the information gathered during a CPS investigation and the proper release of any confidential information.

> (22 VAC 40-705-160 C). Prior to disclosing information to any of the individuals or organizations, and to be consistent with § 63.2-105 of the Code of Virginia, the local department must consider the factors described in subdivisions 1, 2, and 3 of this subsection as some of the factors necessary to determine whether a person has legitimate interest and the disclosure of information is in the best interest of the child:
>
> 1. The information will be used only for the purpose for which it is made available;
>
> 2. Such purpose shall be related to the goal of child protective or rehabilitative services; and
> 3. The confidential character of the information will be preserved to the greatest extent possible.

When a question arises concerning whether certain information contained in a CPS investigative record should be released, the LDSS should consult the local city or county attorney.

9.3.2 Identity of complainant and collaterals to remain confidential

> (22 VAC 40-705-160 D). In the following instances, the local department shall not release child protective services information:
> 1. The local department shall not release the identity of persons reporting incidents of child abuse or neglect, unless court ordered or as required under § 63.2-1503 D of the Code of Virginia, in accordance with § 63.2-1526 of the Code of Virginia, 42 USC § 5101 et seq., and federal regulations (45 CFR Part 1340).
>
> (22VAC 40-705-160 B). The local department may use discretion in disclosing or releasing child protective services case record information, investigative and on-going services to parties having a legitimate interest when the local department deems disclosure to be in the best interest of the child. The local department may disclose such information without a court order and without a written release pursuant to § 63.2-105 of the Code of Virginia.

Federal and state regulations specify that the identity of persons reporting suspected incidents of child abuse or neglect should be protected. However, § 63.2-1503 D of the Code of Virginia provides that the LDSS shall provide the attorney for the Commonwealth and the local law enforcement agency with the information and records of the local department related to the investigation of the complaint, including records related to any complaints of abuse or neglect involving the victim or the alleged perpetrator, and information or records pertaining to the identity of the person who reported the complaint of abuse or neglect. Therefore, the identity of persons reporting suspected incidents of child abuse or neglect is not protected from disclosure in joint investigations involving the attorney for the Commonwealth and the local law enforcement agency. The LDSS shall disclose the identity of persons reporting suspected incidents of child abuse or neglect to the attorney for the Commonwealth and the local law enforcement agency.

Other circumstances may arise where the name of the complainant must be disclosed. This might include court proceedings where the information provided by the complainant is necessary for a full disclosure of the child's situation. Neither state law nor federal regulations provide for confidentiality of the identity of persons providing information on a child abuse and neglect case through collateral contact by the worker. Therefore, individuals making complaints or providing information through collateral

contacts should be informed that the LDSS will maintain the information confidential to the greatest extent possible, but cannot guarantee its confidentiality.

Section 63.2-1514 of the Code of Virginia provides that the subject of an unfounded investigation may petition the circuit court to obtain the identity of the complainant if the person believes the complaint was malicious or made in bad faith. The circuit court may order the release of this information.

9.4 Virginia Freedom of Information Act

Code of Virginia § 2.2-3700 (Virginia FOIA) requires that official records held by public agencies are to be open to inspection. Any individual may exercise his or her Virginia FOIA rights to see public information in the custody of any public agency. It provides procedures for requesting records and responding to those requests. It also provides exceptions to providing certain information to individuals who make requests pursuant to the Code of Virginia.

The provisions of Code of Virginia § 2.2-3700 et seq. apply to the VDSS and the LDSS. Except as otherwise specifically provided by law, all official records shall be open to inspection and copying by any citizen of the Commonwealth during the regular office hours of the custodian of such records. This is a summary of these provisions. For additional information on FOIA, see the VDSS public website.

In all instances of requests for release of information, LDSS are strongly encouraged to seek legal advice and counsel prior to responding to the request.

9.4.1 LDSS shall make an initial response to the individual within five days

When a request for the release of information under the Virginia FOIA is made, the LDSS shall make an initial response to the individual requesting the information **within five (5) working days** after the receipt of the request.

9.4.2 Requesting party shall specify what information is requested

The requesting party shall designate the requested records with reasonable specificity. The requesting party does not need to specify that the release is to be in accordance with the Virginia FOIA to invoke the provisions of Code of Virginia § 2.2-3700 et seq. and the time limits for response by the LDSS.

9.4.3 Initial response by LDSS may vary

The LDSS shall respond to the request for the release of information in one of the following methods:

- The requested records shall be provided to the requesting citizen.
- If the LDSS determines that an exemption applies to all of the requested records, the LDSS may refuse to release such records. The LDSS shall provide to the requesting party a written explanation as to why the records are not available; making specific reference to the applicable Code of Virginia sections that make the requested records exempt.
- If the LDSS determines that an exemption applies to a portion of the requested records, the LDSS may redact that portion of the records that should remain confidential. The LDSS shall disclose the remainder of the requested records and provide to the requesting party a written explanation as to why certain portions of the record are not available to the requesting party, making specific reference to the applicable Code of Virginia sections making that portion of the requested records exempt. Any reasonably segregatable portion of an official record shall be provided to any person requesting the record after the deletion of the exempt portion.
- If the LDSS determines that it is practically impossible to provide the requested records or to determine whether they are available within the five-work-day period, the LDSS shall inform the requesting party. The LDSS shall have an additional **seven (7) working days** in which to provide one of the three (3) preceding responses.

9.4.4 LDSS may petition the court for additional time to respond

The LDSS may petition the appropriate court for additional time to respond to a request for records when the request is for an extraordinary volume of records and a response by the LDSS within the time required by the Code of Virginia will prevent the LDSS from meeting its operational responsibilities. Before filing this petition, however, the LDSS shall make reasonable efforts to reach an agreement with the requesting party concerning the production of the records requested.

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9.4.5 LDSS may charge a fee

The LDSS may make reasonable charges for the copying, search time, and computer time expended in providing the requested information.

9.4.6 Requesting information that does not exist

The LDSS is not required to create or prepare a particular requested record if it does not already exist. The LDSS may, but is not required to, abstract or summarize information from official records or convert an official record available in one form into another form at the request of the citizen. The LDSS shall make reasonable efforts to reach an agreement with the requesting party concerning the production of the records requested.

9.4.7 LDSS shall take action upon request

Failure to make any response to a request for records constitutes a violation of Code of Virginia § 2.2-3700 et seq. and will be deemed a denial of the request.

9.4.8 Exceptions to release of information

The Code of Virginia § 2.2-3700 et seq. provides exceptions from the provisions of the Virginia FOIA, but may be disclosed by the LDSS at the LDSS's discretion, except where such disclosure is prohibited by law. For the exceptions to the Virginia FOIA specific to social services, see Code of Virginia § 2.2-3705.5.

The VAC states:

> (22VAC40-705-160 D). In the following instances, the local department shall not release child protective services information:
> 1. The local department shall not release the identity of persons reporting incidents of child abuse or neglect, unless court ordered or as required under § 63.2-1503 D of the Code of Virginia, in accordance with § 63.2-1526 of the Code of Virginia, 42 USC § 5101 et seq., and federal regulations (45 CFR Part 1340).
> 2. In all complaints or reports that are being investigated jointly with law enforcement, no information shall be released by the local department prior to the conclusion of the criminal investigation unless authorized by the law enforcement officer or his supervisor or the attorney for the Commonwealth pursuant to § 63.2-1516.1 B of the Code of Virginia.

In all complaints or reports that are being investigated jointly with law enforcement, no information shall be released by the LDSS unless authorized by the law enforcement officer, their supervisor or the local Commonwealth Attorney.

In all instances of exceptions to release of information, LDSS are strongly encouraged to seek legal advice and counsel prior to responding to the request.

9.5 Government Data Collection and Dissemination Practices Act

(§ 2.2-3806 3 of the Code of Virginia). Upon request and proper identification of any data subject, or of his authorized agent, grant the data subject or agent the right to inspect, in a form comprehensible to him:

a. All personal information about that data subject except as provided in subdivision 1 of § 2.2-3705.1, subdivision 1 of § 2.2-3705.4, and subdivision 1 of § 2.2-3705.5.
b. The nature of the sources of the information.

c. The names of recipients, other than those with regular access authority, of personal information about the data subject including the identity of all persons and organizations involved and their relationship to the system when not having regular access authority, except that if the recipient has obtained the information as part of an ongoing criminal investigation such that disclosure of the investigation would jeopardize law-enforcement action, then no disclosure of such access shall be made to the data subject.

9.5.1 General provisions for collecting confidential data

The LDSS shall adhere to the following principles of information practice to ensure safeguards for personal privacy:

- There shall be no personal information system whose existence is secret.
- Information shall not be collected unless the need for it has been clearly established in advance.
- Information shall be appropriate and relevant to the purpose for which it has been collected.
- Information cannot be obtained by fraudulent or unfair means.
- Information shall be accurate and current.

9.5.2 The rights of the data subjects

Upon request and proper identification of any data subject, or of his authorized agent, the LDSS shall grant such subject or agent the right to inspect, in a form comprehensible to such individual or agent:

- All personal information about that data subject except as provided in Code of Virginia §§ 2.2-3705.1, 2.2-3705.4, and 2.2-3705.5.
- The nature of the sources of the information.
- The names of recipients, other than those with regular access authority, of personal information about the data subject including the identity of all persons and organizations involved and their relationship to the system when not having regular access authority, except that if the recipient has obtained the information as part of an ongoing criminal investigation such that disclosure of the investigation would jeopardize law-enforcement action, then no disclosure of such access shall be made to the data subject.

9.5.3 Minimum conditions of disclosure

The LDSS shall comply with the following minimum conditions of disclosure:

- The LDSS shall make disclosures to data subjects required under this chapter, during normal business hours.
- The disclosures to data subjects required under this chapter shall be made (i) in person, if he appears in person and furnishes proper identification, or (ii) by mail, if he has made a written request, with proper identification. Copies of the documents containing the personal information sought by a data subject shall be furnished to him or his representative at reasonable standard charges for document search and duplication.

9.5.4 Requesting party may seek representative

The data subject seeking the release of personal information shall be permitted to be accompanied by a person or persons of his choosing, who shall furnish reasonable identification. The LDSS may require the data subject to furnish a written statement granting permission to the organization to discuss the individual's file in such person's presence.

9.5.5 Exception to Government Data Collection and Dissemination Practices Act

The provisions of Code of Virginia § 2.2-3800 et seq. are not applicable to personal information systems maintained by LDSS regarding alleged cases of child abuse or neglect while such cases are also subject to an ongoing criminal prosecution. For additional exceptions to disclosing personal information pursuant to the Government Data Collection and Dissemination Practices Act, see Code of Virginia § 2.2-3802.

9.6 Release information to the alleged abuser or neglector

9.6.1 Alleged abuser or neglector is entitled to information about himself

The alleged abuser or neglector maintains the right to access information about himself, including the right to examine a copy of the child welfare information system form subject to the restrictions in this guidance manual. The VAC states:

> (22 VAC 40-705-160 A3). Any individual, including an individual against whom allegations of child abuse or neglect were made, may exercise his rights under the Government Data Collection and Dissemination Practices Act (§ 2.2-3800 et seq. of the Code of Virginia) to access personal information related to himself that is contained in the case record, including, with the individual's notarized consent, a search of the Central Registry.

9.6.2 Alleged abuser or neglector may review medical and psychological information about himself

The alleged abuser or neglector maintains the right to see medical and psychological information about himself. However, if the treating doctor attached a statement to the medical or psychological information that the alleged abuser's or neglector's access to the information could be harmful to the alleged abuser's or neglector's physical or mental health or well-being as specified in the Code of Virginia § 32.1-127.1:03 F , the LDSS may withhold access. Otherwise, medical and psychological information must be released on request.

9.6.3 No special provisions for the release of information to parent, guardian, or caretaker of the alleged victim child

The Government Data Collection and Dissemination Practices Act of Virginia does not specifically address a parent's or guardian's right to see the personal information in the record about the child.

If the parent or guardian, whether custodial or non-custodial, requests personal information about the child and the LDSS believes that the release of the information would be contrary to the child's best interest, then the LDSS may deny that request.

If the LDSS believes the release of information would be in the child's best interest, such information may be released with the exception of medical or psychological information to which the treating physician attached a statement that the client's access to the information could be harmful to the client's physical or mental health or well-being. The parent should be referred to the source for access to this information.

The parent, caretaker, or guardian is entitled to access to any personal information about himself that is contained in the CPS record pursuant to the Government Data Collection and Dissemination Practices Act.

9.6.4 Reasonable time to edit record for release

When the alleged abuser or neglector requests information, the VAC provides the LDSS reasonable time to redact or edit the information needing to be protected. The VAC provides:

> (22 VAC 40-705-160 A4). When the material requested includes personal information about other individuals, the local department shall be afforded a reasonable time in which to redact those parts of the record relating to other individuals.

The LDSS must ensure that the alleged abuser or neglector is only provided access to that portion of the record concerning him with safeguards taken to assure the privacy rights of the other persons mentioned in the case record including protecting the name of the complainant.

9.6.5 LDSS must respond to request with reasonable promptness

When the alleged abuser or neglector makes a request, pursuant to the Government Data Collection and Dissemination Practices Act, to see his personal information in the case record, the LDSS must respond to this request with reasonable promptness. However, the Virginia FOIA and the Government Data Collection and Dissemination Practices Act contain exceptions. Not all information can be released to the individual making the request.

9.6.6 Alleged abuser or neglector may designate representative

The right to access information may be exercised directly by the individual or by any representative of his choice designated by him in writing.

9.6.7 Criminal investigation/prosecution suspends access to records

Code of Virginia § 2.2-3802 7 establishes that during a criminal investigation, the alleged abuser's or neglector's right to access the records of a CPS investigation is suspended. The VAC reflects the statutory intent:

> (22 VAC 40-705-160 A7). An individual's right to access to information under the Government Data Collection and Dissemination Practices Act is stayed during criminal prosecution pursuant to § 63.2-1526 C of the Code of Virginia.

The provisions for releasing information of a CPS investigation, pursuant to the Government Data Collection and Dissemination Practices Act, are suspended when there is a criminal investigation involving the same case.

Pursuant to § 63.2-1516.1 B of the Code of Virginia, in all complaints or reports that are being investigated jointly with law enforcement, no information shall be released by the LDSS unless authorized by the law enforcement officer, their supervisor or the local Commonwealth Attorney.

9.6.8 Release of information when founded disposition is appealed

Prior to the LDSS rendering a disposition, the LDSS may only release confidential information to the alleged abuser or neglector pursuant to the Government Data Collection and Dissemination Practices Act and consistent with the Code of Virginia and VAC.

The Code of Virginia provides for greater disclosure of the CPS record after the LDSS renders a disposition. Code of Virginia § 63.2-1526 specifies an alleged abuser's access to the CPS record. If the LDSS has information in its record that has been used in making the founded disposition, the alleged abuser has the right to access that information on appeal. The exceptions are as follows:

- The identity of the person making the complaint.
- Any information which may harm a child.

- The identity of collateral witnesses, when disclosure may endanger his life or safety.
- The identity of any other person, when disclosure may endanger his safety.
- Information prohibited from disclosure by state and federal law.

In general, if the victim's medical records were used in making the founded determination, then the alleged abuser is entitled to see that information.

It is up to the LDSS to use good judgment in deciding what should be released and what should be withheld. The LDSS must be able to adequately defend its decision when challenged. This issue underscores the need for LDSS to consult with legal counsel when records have been requested.

9.6.8.1 Appellant shall be informed of procedures for making information available and withholding information

The appellant has the right to be informed of the procedure by which information will be made available or withheld. If information is withheld, the appellant shall be advised of the general nature of such information, the reason the information is being withheld, and the appellant's right to petition the juvenile and domestic relations court, or family court, to enforce any request for information which has been denied.

9.6.8.2 Appellant's access to CPS record is stayed during criminal proceeding or investigation

The Code of Virginia § 63.2-1526 C stays (i.e., suspends) the appellant's right to access the LDSS record during the administrative appeal process whenever a criminal charge involving the same appellant for the same conduct involving the same victim is proceeding. The Code of Virginia § 63.2-1526 C also stays (i.e., suspends) the appellant's right to access the LDSS record during the administrative appeal process whenever a criminal investigation is filed or commenced against the appellant for the same conduct involving the same victim as investigated by the local department until the criminal investigation is closed or 180 days have passed since the appellant's request for an appeal, whichever occurs first.

9.7 Release information to legitimate interests

If an LDSS receives a request for information about a CPS case, and release of that information is not mandated or prohibited by Federal law, the Code of Virginia, or the VAC, then release of that information is at the discretion of the LDSS. All records and statistical registries of the LDSS and of the local boards, including child protective service records, are confidential. Code of Virginia §§ 63.2-104 and 63.2-105 provide access to a person with a legitimate interest when access is in the best interest of the child.

In all instances of requests for release of information, LDSS are strongly encouraged to seek legal advice and counsel prior to responding to the request.

9.7.1 Authority to release information when disclosure is not mandated

The VAC summarizes the authority to release information to persons when that release is not mandated.

> (22 VAC 40-705-160 B). The local department may use discretion in disclosing or releasing child protective services case record information, investigative and on-going services to parties having a legitimate interest when the local department deems disclosure to be in the best interest of the child. The local department may disclose such information without a court order and without a written release pursuant to § 63.2-105 of the Code of Virginia.

Each request for or act of disclosure must be individually evaluated. Evaluating the request for information is a two-step process. The first consideration is whether disclosure of the requested information is in the best interest of the child. The second consideration is whether the party requesting the information has a legitimate interest.

9.7.2 Definition of legitimate interest

The definition section of the VAC defines legitimate interest as:

> (22 VAC 40-705-10). "Legitimate interest" means a lawful, demonstrated privilege to access the information as defined in § 63.2-105 of the Code of Virginia.

9.7.3 Identify parties with legitimate interest

Individuals and organizations considered to have a legitimate interest include, but are not limited to:

- An agency having the legal or designated authority to treat or supervise a child who is the subject of a complaint.
- The administrator of an institution in cases involving abuse or neglect by an employee of the facility.
- Members of a multidisciplinary team, a family assessment, or a planning team.
- Police, other law-enforcement agency, or Commonwealth's attorney.
- A physician treating an allegedly abused or neglected child.
- A person legally authorized to place a child in protective custody.
- A parent, guardian, or other person who is responsible for the welfare of a child.
- The guardian ad litem for the child.
- Military Family Advocacy Program.
- A grand jury upon its determination that access to such records is necessary in the conduct of its official business.
- Any appropriate state or local agency responsible for child protective services.
- A legislator carrying out official functions.
- Any person engaged in a bona fide research project if the information is absolutely essential to the research purpose. The director of the Division of Family Services must give prior approval.
- A person who is responsible for investigating a report of known or suspected abuse or neglect.
- A state or local government child welfare or human service agency when they request information to determine the compliance of any person with a CPS plan or order of any court.
- Personnel of the school or child day program (as defined in Code of Virginia § 63.2-100) attended by the child so that the LDSS can receive information from

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such personnel on an ongoing basis concerning the child's health and behavior and the activities of the child's custodian.

- A parent, grandparent, or any other person when they would be considered by the LDSS as a potential caretaker of the child in the event the department has to remove the child from his current custodian.

- Pursuant to Code of Virginia § 37.2-905.2, the Department of Corrections, the Commitment Review Committee, and the Office of the Attorney General may request information from the LDSS about an inmate who is subject to a civil commitment hearing as a sexually violent predator.

- Pursuant to Code of Virginia § 63.2-104, *the staff of (i) a court services unit, (ii) the Department of Juvenile Justice, (iii) a local community services board, or (iv) the Department of Behavioral Health and Developmental Services who are providing treatment, services, or care for a child who is the subject of such records for a purpose relevant to the provision of the treatment, services, or care when the local agencies have entered into a formal agreement with the Department of Juvenile Justice to provide coordinated services to such children.*

The identification of a party as having a legitimate interest must be consistent with Code of Virginia § 63.2-105 A.

9.8 Release child's location

Pursuant to §§ 63.2-1505 and 63.2-1506 of the Code of Virginia, LDSS, upon request, must disclose to the child's parent or guardian the location of the child, provided that:

- The investigation or family assessment has not been completed;

- The parent or guardian requesting disclosure of the child's location has not been the subject of a founded report of child abuse or neglect;

- The parent or guardian requesting disclosure of the child's location has legal custody of the child and provides to the local department any records or other information necessary to verify such custody;

- The local department is not aware of any court order, and has confirmed with the child's other parent or guardian or other person responsible for the care of

the child that no court order has been issued, that prohibits or limits contact by the parent or guardian requesting disclosure of the child's location with the child, the child's other parent or guardian or other person responsible for the care of the child, or any member of the household in which the child is located; and

- Disclosure of the child's location to the parent or guardian will not compromise the safety of the child, the child's other parent or guardian, or any other person responsible for the care of the child.

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10

SUBSTANCE-EXPOSED INFANTS

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TABLE OF CONTENTS

DRAFT

DRAFT

10

SUBSTANCE-EXPOSED INFANTS

10.1 Introduction

The Code of Virginia § 63.2-1509 B requires the local department of social services (LDSS) to accept as valid a report that a newborn infant may have been exposed to controlled substances prior to birth. This part of the CPS guidance chapter explains how the Code of Virginia impacts:

- Mandated reporting of substance-exposed infants (SEI) and the validity decision.
- CPS family assessments and investigations.
- Services to the families of SEI.
- Possible court actions.

In utero substance exposure can cause or contribute to premature birth, low birth weight, increased risk of infant mortality, neurobehavioral and developmental complications. Post-natal environmental factors associated with maternal substance use such as poverty, neglect and unstable or stressful home environments present additional risks for these children.

Interventions to reduce adverse outcomes and promote healthy home environments are critical to the well-being of SEI and their families.

Additional information on SEI and maternal substance use can be found by accessing:

- CWSE5501: Substance Abuse. This on-line course has four (4) modules and is available in the Virginia Learning Center (VLC).

DRAFT

- National Center on Substance Abuse and Child Welfare, including an online tutorial, "Understanding Substance Use Disorders, Treatment, and Family Recovery: A Guide for Child Welfare Professionals."

- Children and Family Futures. This agency provides a library of various recorded webinars conducted in 2015 regarding SEI and child welfare.

- Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation.

- Virginia Department of Behavioral Health and Developmental Services (DBHDS) provides resources for pregnant and parenting women and their families.

- CWSE6010: Working with Families of Substance Exposed Infants. This on-line course has two (2) modules and is available in the Virginia Learning Center (VLC).

10.2 SEI Definitions

The following definitions pertain to substance use disorders and SEI referrals:

Term	Definition
Assessment-(Substance Use)	Assessment refers to an in-depth look at an individual's past and current substance use and the impact of that use on the overall functioning of that individual. Assessment is a process for defining the nature of that problem, determining a diagnosis, and developing specific treatment recommendations for addressing the problem or diagnosis.
Dual diagnosis	Dual diagnosis refers to co-occurring Mental Health and Substance Use disorders (alcohol and/or drug dependence or abuse).

DRAFT

Fetal Alcohol Spectrum Disorder (FASD)	Fetal alcohol spectrum disorders (FASD) is an umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy. These effects may include physical, mental, behavioral, or learning disabilities with possible lifelong implications. See Appendix A for more information.
Medication-Assisted Treatment (MAT)	Medication-Assisted Treatment, which includes some Opioid Treatment Programs (OTP), combines behavioral therapy and medications to treat substance use disorders.
Neonatal Abstinence Syndrome (NAS)	Neonatal abstinence syndrome (NAS) is a group of problems that occur in a newborn as a result of sudden discontinuation of addictive opioids, licit or illicit, to which the newborn was exposed while in the mother's womb. See Appendix B for more information.
Opioid Treatment Program (OTP)	An Opioid Treatment Program (OTP) provides medication assisted treatment for the treatment of opioid addiction. OTPs may also provide comprehensive, individually tailored programs that can include: • Medication therapy • Psychosocial and medical treatment • Support services that address factors affecting the client.
Screening	A screening is a brief preliminary interview with an individual intended to determine if that individual may be at risk to have problems in a certain area such as substance abuse. Screening does not identify substance abuse or dependency nor does it provide a substance use disorder diagnosis. It is a quick way to determine if someone needs to be referred for further assessment. Screening refers to the use of tools and procedures designed to determine the risk or probability that an individual has a given condition or disorder. Screening may be a combination of observation, open-ended questions, and/or the use of a standardized set of questions.

DRAFT

Screening tools	Screening tools have been developed to help identify individuals at risk for various disorders or problems such as substance use disorders or domestic violence. See Appendix C for two screening tools used to help identify substance abuse.
Substance abuse counseling or treatment services	These are professional services provided to individuals for the prevention, diagnosis, or treatment of chemical dependency. Substance abuse counseling or treatment should include education about the impact of alcohol and other drugs on the fetus and on the maternal relationship; and education about relapse prevention to recognize personal and environmental cues which may trigger a return to the use of alcohol or other drugs. The substance abuse counseling or treatment services must be provided by a professional (e.g., a "certified substance abuse counselor" or a "licensed substance abuse treatment practitioner").

10.3 Background of SEI

10.3.1 Federal law

- The Child Abuse and Prevention Treatment Act (CAPTA) of 1974 was created to provide federal funding to support prevention, assessment, investigation, prosecution and treatment activities related to child abuse and neglect.
- The Keeping Children and Families Safe Act of 2003 created new conditions for states to receive grant allocations under CAPTA. The grant conditions were intended to provide needed services and support for infants, their mothers, and their families, and to ensure a comprehensive response to the effects of prenatal drug exposure.
- The CAPTA Reauthorization Act of 2010 made further changes related to prenatal exposure issues to include identification of infants affected by Fetal Alcohol Spectrum Disorder (FASD) and a requirement for the development of Plans of Safe Care for infants affected by FASD.

DRAFT

- The Comprehensive Addiction and Recovery Act (CARA) of 2016 went into effect July 22, 2016, including Title V, Section 503, "Infant Plan of Safe Care." The legislation (PL 114-198) made several changes to CAPTA and SEI:
    - Removed the term "illegal" in regards to substance abuse
    - Requires that Plans of Safe Care address the needs of both the infant and the affected family or caregiver
    - Specifies that data on affected infants and Plans of Safe Care be reported by states to the maximum extent practicable. Such data includes:
        - The number of infants identified as being affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure, or FASD.
        - The number of infants for whom a plan of safe care was developed.
        - The number of infants for whom referrals were made for appropriate services—including services for the affected family or caregiver.
- Requires that states develop and implement monitoring systems regarding the implementation of such plans to determine whether and in what manner local entities are providing, in accordance with state requirements, referrals to and delivery of appropriate services for the infant and affected family or caregiver.

10.3.2 Virginia law

Virginia laws have been implemented and revised in accordance with the changes made to CAPTA. In the 2017 Session of the General Assembly, a bill was passed amending §§ 63.2-1505, 63.2-1506, and 63.2-1509 relating to CPS investigations, family assessments, and Virginia's mandated child abuse and neglect reporting requirements to comply with CARA. The changes to the Code of Virginia became effective July 1, 2017.

Amendments made to the relevant sections of the Code of Virginia to comply with CARA include:

- Section 63.2-1505 of the Code of Virginia, Subsection B(2) was amended to (1) eliminate language referencing an obsolete procedure, and (2) move language addressing substance-exposed infants out of this section that

pertains to CPS investigations and into §§ 63.2-1506 and 63.2-1509 of the Code of Virginia pertaining to family assessments and mandated reporting, respectively.

- Section 63.2-1506 of the Code of Virginia was amended to add Subsection A(4), which requires LDSS to gather information as to "[w]hether the mother of a child who was exposed in utero to a controlled substance sought substance abuse counseling or treatment prior to the child's birth" when conducting family assessments.

- Section 63.2-1506 of the Code of Virginia was further amended to add the following to Subsection C: "If a report or complaint is based upon one of the factors specified in subsection B of § 63.2-1509, the local department shall (a) conduct a family assessment, unless an investigation is required pursuant to this subsection or other provision of law or is necessary to protect the safety of the child, and (b) develop a plan of safe care in accordance with federal law, regardless of whether the local department makes a finding of abuse or neglect."

- Section 63.2-1509 of the Code of Virginia, Subsection B, was amended to read: a "'reason to suspect that child is abused or neglected shall include (i) a finding made by a health care provider within six weeks of the birth of a child that the child was born affected by substance abuse or experiencing withdrawal symptoms resulting from in utero drug exposure; (ii) a diagnosis made by a health care provider within four years following a child's birth that the child has an illness, disease, or condition that, to a reasonable degree of medical certainty, is attributable to maternal abuse of a controlled substance during pregnancy; or (iii) a diagnosis made by a health care provider within four years following a child's birth that the child has a fetal alcohol spectrum disorder attributable to in utero exposure to alcohol. When 'reason to suspect' is based upon this subsection, such fact shall be included in the report along with the facts relied upon by the person making the report."

10.4 Mandated reporting of SEI

The Code of Virginia and the Virginia Administrative Code (VAC) provide for the mandated reporting of SEI. Effective July 1, 2017, § 63.2-1509 B of the Code of Virginia was significantly revised and supersedes the VAC, 22VAC40-705-40 A5.

10.4.1 Health care providers required to report SEI

The Code of Virginia specifically delineates three (3) circumstances which constitute a reason to suspect that a newborn infant is abused or neglected due to the special medical needs of infants affected by substance exposure and therefore requires a report to CPS by health care providers. Such reports shall not constitute a per se finding of child abuse or neglect.

As a result of federal legislation, i.e., CARA (2016), SEI now includes both legal and illegal controlled substance exposure.

10.4.1.1 First circumstance

> (§ 63.2-1509 B of the Code of Virginia) (i) a finding made by a health care provider within six weeks of birth of a child that the child was born affected by substance abuse or experiencing withdrawal symptoms resulting from in utero drug exposure;

The first circumstance is a finding is made by a health care provider within six (6) weeks of birth that the child is born affected by substance abuse or is experiencing withdrawal symptoms resulting from in utero drug exposure.

10.4.1.1.1 Affected by substance abuse

Affected by substance abuse may be evidenced by impaired growth, pre-term labor or subtle neurodevelopmental signs that are more difficult to define in the newborn and infancy stages. An alcohol or other drug affected infant is one in which there is detectable physical, developmental, cognitive or emotional delay or actual harm that is associated with parental substance use.

A positive toxicology for substances in the infant may or may not indicate that the child was born affected by substance abuse. If it is known that the drug was prescribed to the mother and is being used appropriately, the referral could be screened out. Conversely, if the mother has a positive toxicology at the time of the infant's birth or has had a medical or behavioral health assessment that is indicative of an active substance use disorder and she is demonstrating behaviors that may impact her capacity to provide proper care for the infant, or if there is a history of prior referrals involving substance abuse, the referral should be screened in.

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In instances when a health care provider reports a positive toxicology result for a newborn child to a LDSS, but there is no other evidence or finding by the health care provider that the child was born affected by substance use or is experiencing withdrawal symptoms, the LDSS should make further inquiry into the circumstances of the report to determine whether the report should be screened in in accordance with §§ 63.2-1509(B) and § 63.2-1503(I) of the Code of Virginia. Further inquiry should include asking the health care provider for all related information, records, and reports that form the basis of his or her suspicion that the infant is an abused or neglected child in accordance with § 63.2-1509(B).

The LDSS may not have a blanket policy which reflects that a positive toxicology report, standing alone, is or is not a valid referral. The LDSS must exercise its professional discretion and judgment in light of the information gathered from the health care provider to determine whether such report is valid.

The LDSS must gather enough information from the health care provider making the report to indicate that a finding has been made that the newborn child was born affected by substance abuse as described in Section 10.4.1.1. Once the LDSS has determined that the health care provider has made such a finding, the report should be screened in as a family assessment (or investigation when required) and a Plan of Safe Care developed. The LDSS must document that the report was based on § 63.2-1509 (B) of the Code of Virginia along with the facts relied upon by the health care provider who made the report.

10.4.1.1.2 Withdrawal symptoms resulting from in utero drug exposure

This first circumstance also includes when a child has withdrawal symptoms due to dependency to a drug while in utero. This includes dependency on controlled substances prescribed for the mother by a physician or an opioid treatment program (OTP).

In utero exposure to certain drugs can cause neonatal withdrawal after birth when the drug is abruptly stopped because the infant, like the mother, has developed physical dependence on the drug. Clinically relevant neonatal withdrawal most commonly results from in utero opioid exposure but has also been described in infants exposed to benzodiazepines, barbiturates, and alcohol. Neonatal Abstinence Syndrome (NAS) is a group of problems that

occur in a newborn as a result of sudden discontinuation of addictive opioids, licit or illicit, to which the newborn was exposed while in the mother's womb. Because NAS is treatable, treatment providers typically recommend medication-assisted treatment (MAT) over abstinence for pregnant, opioid-addicted women. Additional information regarding NAS can be found in Appendix B.

10.4.1.2 Second circumstance

> (§ 63.2-1509 B of the Code of Virginia) (ii) a diagnosis made by a health care provider within four years following a child's birth that the child has an illness, disease, or condition that, to a reasonable degree of medical certainty, is attributable to abuse of a controlled substance during pregnancy;

The second circumstance is within four (4) years of a child's birth, a health care provider can diagnose the child as having an illness, disease or condition which, to a reasonable degree of medical certainty, is attributable to in utero exposure to a controlled substance.

10.4.1.3 Third circumstance

> (§ 63.2-1509 B of the Code of Virginia) (iii) a diagnosis made by a health care provider within four years following a child's birth that the child has a fetal alcohol spectrum disorder attributable to in utero exposure to alcohol.

The third circumstance is within four (4) years following a child's birth, a health care provider can make the diagnosis that the child has a fetal alcohol spectrum disorder (FASD) attributable to in utero exposure to alcohol. See Appendix A of this section for additional information regarding FASD.

10.4.2 Health care provider responsibilities

10.4.2.1 Report to CPS

> (22 VAC 40-705-40 A6). Pursuant to § 63.2-1509 B of the Code of Virginia, whenever a health care provider makes a finding or diagnosis, then the health care provider or his designee must make a report to child protective services immediately.

Whenever a health care provider makes a finding or diagnosis of one (1) of the three (3) circumstances above, the health care provider shall make a report to

CPS as soon as possible, but no longer than **24 hours** after having reason to suspect a reportable situation.

When reporting SEI, health care providers are required to release, upon request, medical records that document the basis of the report. Disclosure of child abuse or neglect information is also permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and federal Confidentiality of Alcohol and Drug Abuse Patient Information Regulations. (CFR 42 Part 2)

10.4.2.2 Report to the Community Services Board

The Code of Virginia §§ 32.1-127 B6 and 63.2-1509 B require that each licensed hospital develop and implement a protocol requiring written discharge plans for identified, substance-abusing, postpartum women and their infants. The discharge plan should be discussed with the patient and appropriate referrals made and documented. The discharge planning process shall involve, to the extent possible, the father of the infant and any members of the mother's extended family who may participate in the follow-up care for the mother and the infant. Hospitals are required to notify the Community Services Board (CSB) of the jurisdiction in which the woman resides to appoint a discharge plan manager for any identified substance-abusing postpartum woman. The CSB shall implement and manage the discharge plan.

10.4.2.2.1 Hospital discharge plan

Post-partum women with substance use disorders and their newborns may have multiple health care, treatment, safety and environmental needs. Their hospital discharge plans should include, but are not limited to:

- A referral of the mother to the local CSB for a substance use assessment and implementation of the discharge plan.
- Information and medical directives regarding potential postpartum complications and, as appropriate, indicators of substance use withdrawal and post-partum depression.
- A follow-up appointment for pediatric care for the infant within two-four weeks.

- A referral to early intervention Part C services for a developmental assessment and early intervention services for the infant.
- A follow-up appointment for the mother for postpartum gynecological care and family planning.

The CPS worker should obtain a copy of the hospital discharge plan and document the details in the child welfare information system.

10.5 Plans of Safe Care

Section 106(b)(2)(B)(iii) of the Child Abuse Prevention and Treatment Act (CAPTA) requires "the development of a plan of safe care for the infant born and identified as being affected by substance abuse or withdrawal symptoms or Fetal Alcohol Spectrum Disorder". The Plan of Safe Care should address the needs of the child as well as those of the parent, as appropriate, and assure that appropriate services are provided to ensure the infant's safety.

10.5.1 Who creates a Plan of Safe Care?

A Plan of Safe Care should begin when the mother is pregnant and be initiated by her health care providers. Once the LDSS becomes involved in a SEI referral, the LDSS becomes a part of this Plan of Safe Care. The LDSS is one of many agencies that can provide a Plan of Safe Care for the SEI and the mother.

The following chart identifies three general populations of pregnant and post-partum women and who would typically create or take the lead in monitoring a Plan of Safe Care.

Populations of pregnant and post-partum women	**Potential lead agency/provider for the Plan of Safe Care**	
	Voluntary Participation During Prenatal Period	**Identified at Birth and Infant is Determined to be Affected**
1. Using legal or illegal drugs, on an opioid medication for chronic pain or on a medication that can	Prenatal care provider in concert with pain	Maternal and Child Health service providers (e.g. home

result in dependency/withdrawal and **does not have a substance use disorder.**	specialist or other physician	visiting provider, Healthy Families); LDSS or community prevention services provider
2. Receiving medication assisted treatment for an opioid use disorder (e.g. Methadone)or is **actively engaged in treatment for a substance use disorder.**	Prenatal care provider in concert with OTP or other therapeutic substance use disorder treatment provider/CSB.	OTP or other therapeutic substance use disorder treatment provider/CSB.
3. Misusing prescription drugs, or is using legal or illegal drugs, **meets criteria for a substance use disorder, not actively engaged in a treatment program.**	Prenatal care provider or high-risk pregnancy clinic in concert with substance use disorder treatment agency/CSB	Child Welfare

10.5.2 What is included in a Plan of Safe Care?

A Plan of Safe Care should incorporate the mother's (and potentially the other primary caregivers) need for treatment for substance use and mental disorders, appropriate care for the infant who may be experiencing neurodevelopmental or physical effects or withdrawal symptoms from prenatal substance exposure and services and supports that strengthen the parents' capacity to nurture and care for the infant and to ensure the infant's continued safety and well-being. The plan should also ensure a process for continued monitoring of the family and accountability of responsible agencies such as substance use disorder treatment, home visiting, and public health and health care providers for the infant and mother.

A sample template for a Plan of Safe Care is located in Appendix D.

10.6 CPS response to SEI referrals

A report with facts indicating the presence of one of the three (3) circumstances outlined in the Code of Virginia § 63.2-1509 B prior to birth are sufficient, in and of themselves, to suspect that the child is abused or neglected and therefore constitutes a valid report

requiring a CPS response. Although, the validity of such reports does not constitute a per se finding of child abuse or neglect.

Substance use, either during pregnancy or after the birth of an infant, does not in or of itself constitute a preponderance of evidence needed to substantiate abuse or neglect. Although caretakers may be able to care for the child, the use or abuse of drugs by caretakers increases the concern for the child's immediate safety and for future risk of harm to the child. When identified, a careful evaluation needs to be made of the impact that the substance use has on the caretaker's capacity to care for the child and the ability to ensure the child's safety and well-being. Such an evaluation will determine whether the child is at substantial risk of harm.

10.6.1 Track decision

Once a report has been made and determined to be valid, the LDSS must determine the response time and track. Effective July 1, 2017, § 63.2-1506 of the Code of Virginia requires all valid referrals involving SEI to be placed in the family assessment track unless an investigation is required by law or is necessary to protect the safety of the child. Because exposure to controlled substances prior to birth is not sufficient evidence for a founded disposition of abuse or neglect in an investigation, a family assessment that assesses safety, risk and service needs of the child and family and does not determine if abuse or neglect has occurred, is usually a more appropriate response.

10.6.1.1 Investigation requirements

According to § 63.2-1506 C of the Code of Virginia, an investigation is required in the following circumstances:

- All sexual abuse allegations;
- Any child fatality;
- Abuse or neglect resulting in serious injury as defined in § 18.2-371.1 also consider medical neglect of disabled infant with life threatening condition (Baby Doe);
- A child's being left alone in the same dwelling with a person to whom the child is not related by blood or marriage and who has been convicted of

an offense against a minor for which registration is required as a violent sexual offender pursuant to § 9.1-902;

- Child taken into agency custody due to abuse or neglect pursuant to § 63.2-1517 ;
- Child taken into protective custody by physician or law enforcement, pursuant to § 63.2-1517; or
- All allegations regarding a caretaker in an out of family setting as defined in § 63.2-1506 C.

A valid SEI allegation must be responded to through a family assessment. However, if the child is removed, the track must be changed to an investigation. Further, the LDSS must document "substance-exposed infant" as at least one of the reasons for removal.

10.6.1.2 Purpose of CPS intervention

The purpose of CPS intervention in response to reports of SEI is to assess both safety and risk factors associated with the newborn child and his family/caretaker(s). This should occur after a health care provider has identified the child as being affected by the abuse of legal or illegal substances by the child's mother. The importance of a CPS response, whether by a family assessment or an investigation, is to mitigate the safety factors and the risk of harm associated with parental substance abuse when caretakers have the responsibility to actively care for this extraordinarily vulnerable population of children.

10.6.2 Initial safety assessment

(22 VAC 40-705-40 A 6 b). When a valid report or complaint alleging abuse or neglect is made pursuant to § 63.2-1509 B of the Code of Virginia, then the local department must immediately assess the child's circumstances and any threat to the child's health and safety. Pursuant to 22VAC40-705-110 A, the local department must conduct an initial safety assessment.

(22 VAC 40-705-40 A 6 c). When a valid report or complaint alleging abuse or neglect is made pursuant to § 63.2-1509 B of the Code of Virginia, then the local department must immediately determine whether to petition a juvenile and domestic relations district court

> for any necessary services or court orders needed to ensure the safety and health of the infant.

The LDSS must complete an initial safety assessment of the SEI and family. Most reports involving a SEI will require a safety plan due to the infants' vulnerability. A safety plan is not the same as a Plan of Safe Care discussed in Section 10.4, but is considered one critical component of the Plan of Safe Care. A safety plan addresses immediate safety concerns and needs, while the Plan of Safe Care addresses both short and long term needs.

When assessing safety factors, it is critical to review the definitions for each safety factor. There are several safety factors that involve substance use and a SEI. The following safety factors will likely pertain to a SEI referral:

- *Safety factor 3. There is evidence that the mother used alcohol or other drugs during pregnancy, AND current circumstances suggest the infant's safety is of immediate concern.*
- *Safety factor 5. Caretaker does not provide supervision necessary to protect child from potentially serious harm. Caretaker's substance or alcohol use is having a serious impact on ability to provide adequate supervision to the child.*

10.6.2.1 Substance use screening

An essential part of the initial safety assessment is to complete a brief substance use screening to determine if a substance abuse assessment is needed and if so, what services would best meet the needs of the mother. A substance use screening should include questions concerning:

- Frequency and amount of alcohol consumption prior to and during pregnancy;
- Frequency and amounts of over-the-counter prescriptions and legal/illegal substances prior to and during pregnancy;
- Effects of substance use on life areas such as relationships, employment, legal, etc.;
- Other parent or partner substance use;

- Previous referrals for substance abuse evaluation or treatment; and
- Previous substance use treatment or efforts to seek treatment.

Two (2) of several universal substance use screening tools used with pregnant and child bearing women (the 4 Ps and 5 Ps) can be found in Appendix C. This screening and safety assessment may lead to consideration of court action or the need to conduct a Family Partnership Meeting (FPM) or both. Additional information regarding screening of pregnant and postpartum women can be found on the DBHDS website.

Initial contacts in SEI cases should include not only the mother and any other parent but also the family's support system. Collateral contacts can confirm or refute information provided by the mother.

10.6.3 Information to gather when responding to SEI referrals

In addition to conditions in the infant, conditions or behaviors in the mother that may indicate that risk of harm should be assessed. These include, but are not limited to:

- special medical and/or physical problems in the infant;
- close medical monitoring and/or special equipment or medications needed by the infant;
- no prenatal care or inconsistent prenatal care;
- previous delivery of a SEI;
- prior CPS history;
- prior removal of other children by the courts or voluntary placement with relatives;
- no preparations for the care of the infant;
- intellectual limitations that may impair the mother's ability to nurture or physically care for the child;
- psychiatric illness;
- home environment that presents safety or health hazards;

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- evidence of financial instability that affects the mother's ability to nurture or physically care for the infant;
- limited or no family support;
- young age of parent(s), coupled with immaturity;
- parenting skills demonstrated in the health care setting that suggest a lack of responsiveness to the SEI's needs (i.e., little or no response to infant's crying, poor eye contact, resistance to or difficulties in providing care); and
- domestic violence.

If the SEI allegation is invalid, the LDSS should evaluate all of the information received in order to assess the report for physical neglect associated with a threat to the infant's health or safety due to substance abuse by his parent(s) and/or other caretaker(s). See Appendix E: Substance Exposed Infant Decision Tree for more information on screening the invalid SEI referral for physical neglect.

10.6.4 No exception to completing the investigation or family assessment

Note that under prior Virginia law, before July, 2017, if the LDSS received a report involving a SEI, but determined that the mother sought and engaged in substance abuse counseling or treatment during pregnancy, the LDSS was not compelled to validate the report. This exception was removed with the changes made to changes to §§ 63.2-1505, 1506, and 1509 of the Code of Virginia in the 2017 General Assembly.

Effective July 1, 2017, once a report of a SEI has been validated, the LDSS shall determine whether the mother sought substance abuse counseling or treatment prior to the child's birth. This information must be documented in the child welfare information system.

10.6.5 Complete the family assessment or investigation

> (22 VAC 40-705-40 A 6 h). Facts solely indicating that the infant may have been exposed to controlled substances prior to birth are not sufficient to render a founded disposition of abuse or neglect in an investigation.

Family assessments or investigations involving a SEI shall be conducted in accordance with Section 4, Family Assessment and Investigation of this guidance manual.

10.6.5.1 Collateral contacts in SEI referrals

Due to the vulnerability of the SEI, collateral involvement to determine risk and possible services is crucial, and may include contacts with the immediate and/or extended family, birthing hospital, pediatrician, and substance use disorder evaluation and treatment providers. When appropriate, the LDSS should coordinate services with the CSB.

Contact with the health care provider(s) should include gathering information:

- to identify how the infant was affected by in utero substance exposure, which may include results of laboratory tests or toxicology studies done on the infant;
- to identify any needed medical treatment for the child or mother;
- to assess the mother's attitude and behavior with the infant;
- to determine the expected discharge dates of the mother and infant; and
- to determine whether there are other children in the home at risk.

Contact with the substance use disorder treatment provider or OTP can provide information on the mother's:

- Plan of Safe Care that was developed while she was pregnant;
- attempts to access treatment;
- compliance with recommendations;
- toxicology results, if applicable;
- assessment results, if applicable; and
- medication assisted treatment dosage and compliance.

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10.6.5.2 Dispositions in SEI investigations

For investigations, facts establishing that the infant was exposed to controlled substances prior to birth are not sufficient to render a founded disposition of abuse or neglect. The LDSS must establish by a preponderance of the evidence that the infant was injured or experienced a threat of injury or harm according to the statutory and regulatory definitions of another type of abuse or neglect to support a founded disposition.

10.6.5.3 Assessing risk in SEI referrals

The Family Risk Assessment tool is used to assess future likelihood of child maltreatment in all referrals, including a SEI.

When assessing risk, it is critical to review the definitions for each factor. There are several risk factor definitions that specifically address the SEI and their caretakers. The following risk factors will likely pertain to a SEI referral:

- N1: Current complaint is for physical or medical neglect. (Score 2 if the current allegation is for a substance-exposed infant.)
- N9: Primary caretaker has/had a drug or alcohol problem. (Score 2 if the child was diagnosed with fetal alcohol syndrome or exposure or child had a positive toxicology screen at birth and the primary caretaker was the birthing parent.)
- N11: Characteristics of children in household. (Score 1 if a child has a positive toxicology report for alcohol or another drug at birth.)

Assessed risk will be:

- **Low**. The assessment of risk related factors indicates that there is a low likelihood of future abuse or neglect and no further intervention is needed.
- **Moderate**. The assessment of risk related factors indicates that there is a moderate likelihood of future abuse or neglect and minimal intervention may be needed.
- **High**. The assessment of risk related factors indicates there is a high likelihood of future abuse or neglect without intervention.

- **Very High**. The assessment of risk-related factors indicates there is a very high likelihood of future abuse or neglect without intervention.

Overrides, either by policy or discretionary, may increase risk one level and require supervisor approval. The initial CPS risk level may never be decreased.

10.6.5.4 Risk level guides decision to open a case

Important reminder: when risk is clearly defined and objectively quantified, resources are targeted to higher-risk families because of the greater potential to reduce subsequent maltreatment. The risk level helps inform the decision whether or not to open a case as follows:

Low Risk:	Close
Moderate Risk:	Open to CPS or close
High Risk:	**Open to CPS**
Very High Risk:	**Open to CPS**

The CPS worker and CPS supervisor should assess the decision to open a case for services and document in the child welfare information system when the decision is to not open a case.

10.6.6 Referral to early intervention programs for children

Regardless if a CPS on-going case is opened for services, the LDSS shall refer any child under the age of three (3) for early prevention services to the local Infant and Toddler Connection of Virginia who:

- Is identified as affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure;
- Is the subject of an investigation with a founded disposition; or
- Has a physical or mental condition that has a high probability of resulting in developmental delay, regardless of track or disposition.

All localities are served by an Infant & Toddler Connection of Virginia program. This referral is required by the Child Abuse Prevention and Treatment Act (CAPTA).

LDSS are encouraged to meet with the local Infant and Toddler program to learn about any referral issues that should be explained to the parent. LDSS are also encouraged

to develop procedures with the Infant & Toddler Connection of Virginia program to make referrals of certain children under age three (3). Recommended elements of these procedures should include:

- As soon as possible but no later than **seven (7) calendar days** of completing the investigation or family assessment the LDSS should send a referral to the local Part C Early Intervention program using the local referral form.

The LDSS should:

- Send a referral as soon as possible when a child has been identified as exposed prenatally to an illegal substance or has withdrawal symptoms at birth.
- Send a copy of the referral to the family. The parent should also be informed verbally of the referral and have an opportunity to discuss the referral process.
- Request the family to sign a release form allowing the exchange of information between the Infant-Toddler Connection Program and the LDSS regarding the referral.
- Document the notification and referral in the state child welfare information system.

More information on the Infant & Toddler programs in Virginia can be found on the Infant & Toddler Connection of Virginia website and on the VDSS internal website in the Memorandum of Agreement dated May 2013 issued by the Commissioners of the Department of Social Services and Department of Behavioral Health and Developmental Services and other agencies involved with implementation of Part C of the Individuals with Disabilities Education Act (IDEA).

10.7 CPS on-going services to families with SEI

Services for mothers with substance use disorders and their families may be different than services for other populations. A thorough assessment done by a certified substance abuse counselor will typically be the first step in providing services for SEI referrals. Assessment refers to an in-depth look at an individual's past and current substance use and the impact of that use on the overall functioning of that individual. Assessment is a process for defining the nature of that problem, determining a diagnosis, and developing specific treatment recommendations for addressing the problem or diagnosis.

10.7.1 Substance abuse services considerations

Special consideration should be given to the following:

- Is outpatient treatment needed and available?
- Is in-patient treatment required and available?
- Is detoxification required?
- Does the individual need a program for dual diagnosed patients?
- Does the individual need assistance in negotiating leave with an employer?
- Does the individual require a program that specializes in a particular addiction?
- Are family members willing to participate in treatment or education?
- Is peer support available through Alcoholics Anonymous (AA), Narcotics Anonymous (NA) or a psychotherapy group?
- Does the treatment facility address the special needs of women and their children?

10.7.2 Other services

In addition to substance abuse services, other services may include but are not limited to:

- Child care.
- Relapse prevention.
- Parenting education.
- Job skills training/employment.
- Mental health assistance.
- Safe housing.
- Support systems.

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Home visiting services match parents and caregivers with trained paraprofessionals who can provide information and support during pregnancy and throughout the child's earliest years. Home visiting programs support healthy prenatal behaviors and parenting attitudes, engage infants in meaningful learning activities build positive parent-child relationships and promote family self-sufficiency. Project Link is one home visiting program offered in Virginia and is specifically for pregnant and parenting substance-using women. For additional information about Project Link and other home visiting programs, such as Healthy Families, go to the Early Impact Virginia website.

10.8 Petition the court on behalf of a SEI

When conducting a SEI investigation, § 16.1-241.3 of the Code of Virginia permits the LDSS to petition the Juvenile and Domestic Relations District Court solely because an infant was exposed to a legal or illegal substance in utero.

> (§ 16.1-241.3 of the Code of Virginia). Newborn children; substance abuse.
>
> Upon the filing of a petition alleging that an investigation has been commenced in response to a report of suspected abuse or neglect of the child based upon a factor specified in subsection B of § 63.2-1509, the court may enter any order authorized pursuant to this chapter which the court deems necessary to protect the health and welfare of the child pending final disposition of the investigation pursuant to Chapter 15 (§ 63.2-1500 et seq.) of Title 63.2 or other proceedings brought pursuant to this chapter. Such orders may include, but shall not be limited to, an emergency removal order pursuant to § 16.1-251, a preliminary protective order pursuant to § 16.1-253 or an order authorized pursuant to subdivisions 1 through 4 of subsection A of § 16.1-278.2. The fact that an order was entered pursuant to this section shall not be admissible as evidence in any criminal, civil or administrative proceeding other than a proceeding to enforce the order.
>
> The order shall be effective for a limited duration not to exceed the period of time necessary to conclude the investigation and any proceedings initiated pursuant to Chapter 15 (§ 63.2-1500 et seq.) of Title 63.2, but shall be a final order subject to appeal.

10.8.1 LDSS may petition juvenile and domestic relations district court

The LDSS should consult with their attorneys when considering petitioning for protective and removal orders as described in Section 8, Judicial Proceedings, of this guidance manual.

The LDSS may petition a juvenile and domestic relation district court for any necessary services or court orders needed to ensure the safety and health of the infant.

10.8.1.1 Petition must allege SEI

The LDSS must state in the petition presented to the court that a CPS investigation or family assessment has been commenced in response to a report of suspected abuse or neglect of the child based upon a factor specified in § 63.2-1509 B of the Code of Virginia.

10.8.2 The court's authority to issue orders

The court may enter any order authorized pursuant to § 16.1-226 et seq. which the court deems necessary to protect the health and welfare of the child. The court may issue such orders as an emergency removal order pursuant to § 16.1-251, a preliminary protective order pursuant to § 16.1-253 or an order authorized pursuant to § 16.1-278.2 A.

For example, such authority would allow the court to remove the child from the custody of the mother pending completion of the investigation or family assessment or compel the mother to seek treatment or other needed services. Code of Virginia § 16.1-241.3 enhances the court's ability to act quickly in a potential crisis situation. In addition, the court will have the ability to use its authority to ensure that the mother of the child seeks treatment or counseling.

10.8.3 Any court order effective until investigation or family assessment is concluded

Any court order issued pursuant to § 16.1-241.3 is effective pending final disposition of the investigation or family assessment pursuant to § 63.2-1500 et seq. The order is effective for a limited duration not to exceed the period of time necessary to conclude the investigation or family assessment and any proceedings initiated pursuant to § 63.2-1500 et seq.

Any order issued pursuant to § 16.1-241.3 is considered a final order and subject to appeal. The fact that an order was entered pursuant to § 16.1-241.3 is not admissible as evidence in any criminal, civil or administrative proceeding other than a proceeding to enforce the order.

10.9 Appendix A: Fetal Alcohol Spectrum Disorder (FASD)

10.9.1 Definition of FASD

Experts now know that the effects of prenatal alcohol exposure extend beyond Fetal Alcohol Syndrome (FAS).

"Fetal alcohol spectrum disorders" (FASD) is an umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy. These effects may include physical, mental, behavioral, and/or learning disabilities with possible lifelong implications. FASD is not a diagnostic term used by clinicians. It refers to conditions such as:

- FAS, including partial FAS.
- Fetal alcohol effects (FAE).
- Alcohol-related neurodevelopmental disorder.
- Alcohol-related birth defects.

10.9.2 Fetal Alcohol Syndrome (FAS)

FAS consists of a pattern of neurologic, behavioral, and cognitive deficits that can interfere with growth, learning, and socialization. FAS has four (4) major components:

- A characteristic pattern of facial abnormalities (small eye openings, indistinct or flat philtrum, thin upper lip).
- Growth deficiencies, such as low birth weight.
- Brain damage, such as small skull at birth, structural defects, and neurologic signs, including impaired fine motor skills, poor eye-hand coordination, and tremors.
- Maternal alcohol use during pregnancy.

Behavioral or cognitive problems may include mental retardation, learning disabilities, attention deficits, hyperactivity, poor impulse control, and social, language, and memory deficits.

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Partial FAS describes persons with confirmed alcohol exposure, facial anomalies, and one other group of symptoms (growth retardation, central nervous system defects, or cognitive deficits).

10.9.3 Fetal alcohol effects (FAE)

FAE describes children with prenatal alcohol exposure who do not have all the symptoms of FAS. Many have growth deficiencies, behavior problems, cognitive deficits, and other symptoms. However, they do not have the facial features of FAS. Although the term FAE is still used, the Institute of Medicine has coined more specific terms. These include alcohol-related neurodevelopmental disorder and alcohol-related birth defects.

10.9.4 Alcohol- related neurodevelopmental disorder (ARND)

ARND refers to various neurologic abnormalities, such as problems with communication skills, memory, learning ability, visual and spatial skills, intelligence, and motor skills. Children with ARND have central nervous system deficits but not all the physical features of FAS. Their problems may include sleep disturbances, attention deficits, poor visual focus, increased activity, delayed speech, and learning disabilities.

10.9.5 Alcohol- related birth defects (ARBD)

ARBD describe defects in the skeletal and major organ systems. Virtually every defect has been described in some patient with FAS. They may include abnormalities of the heart, eyes, ears, kidneys, and skeleton, such as holes in the heart, underdeveloped kidneys, and fused bones.

10.9.6 Cause of FASD

The only cause of FASD is alcohol use during pregnancy. When a pregnant woman drinks, the alcohol crosses the placenta into the fetal blood system. Thus, alcohol reaches the fetus, its developing tissues, and organs. This is how brain damage occurs, which can lead to mental retardation, social and emotional problems, learning disabilities, and other challenges. No alcohol consumption is safe during pregnancy. In addition, the type of alcohol (beer, wine, hard liquor, wine cooler, etc.) does not appear to make a difference.

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10.9.7 Prevalence of FASD

FASD occurs in about 10 per 1,000 live births or about 40,000 babies per year. FAS, the most recognized condition in the spectrum, are estimated to occur in 0.5 to 2 per 1,000 live births. It now outranks Down syndrome and autism in prevalence.

10.9.8 Assessment of FASD

It is extremely difficult to diagnose a FASD. A team of professionals is needed, including a physician, psychologist, speech pathologist, and physical or occupational therapist. Diagnostic tests may include physical exams, intelligence tests, and occupational and physical therapy, psychological, speech, and neurologic evaluations. Diagnosis is easier if the birth mother confirms alcohol use during pregnancy. However, FAS can be diagnosed without confirming maternal alcohol use, if all the symptoms are present.

10.9.9 Impact of FASD

Children with FASD often grow up with social and emotional problems. They may have mental illness or substance abuse problems, struggle in school, and become involved with the corrections system. Costs of FAS alone are estimated at between one (1) and five (5) million dollars per child, not including incarceration. This estimate does not include cost to society, such as lost productivity, burden on families, and poor quality of life.

More information regarding FASD may be accessed at:

Fetal Alcohol Spectrum Disorder Center for Excellence.

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10.10 Appendix B: Neonatal Abstinence Syndrome (NAS)

- What is Neonatal Abstinence Syndrome (NAS)?
    - NAS is a group of problems that occur in a newborn as a result of sudden discontinuation of addictive opioids, licit or illicit, to which the newborn was exposed while in the mother's womb.
- What causes NAS?
    - Almost all drugs pass through the placenta and into the fetus when the mother is pregnant and can cause the fetus to become dependent. At birth, the baby's dependence on that drug continues, however, since the drug is no longer available the baby's central nervous system becomes overstimulated causing symptoms of withdrawal.
    - Infants born to mothers participating in medication assisted treatment (MAT) programs are likely to present with NAS; yet MAT is an EBP for pregnant women that results in better outcomes for mothers with opioid use disorders and her infants (workers need to understand it is better for mom and baby both to be on MAT)
- Why is NAS a concern?
    - When a mother uses illicit substances, she places her baby at risk for many problems. Mothers who use drugs are less likely to seek prenatal care, which can increase risks to her and the baby. Women who use drugs are more likely to use more than one drug, which can complicate the treatment.
    - Additionally, specific difficulties of withdrawal after birth may include, but are not limited to: poor intrauterine growth; premature birth; seizures; and birth defects.
    - Specific drugs often pose specific problems in the baby:
        - Heroin and other opiates (including methadone): significant withdrawal, sometimes lasting four (4) to six (6) months. Seizures may occur from methadone withdrawal.
        - Amphetamines: low birthweight; premature birth.
        - Cocaine: poor fetal growth; developmental delays; learning disabilities; and lower IQ.

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- Marijuana: lower birthweights.
- Alcohol: slow growth during pregnancy and after birth; deformities of the head and face; heart defects; and intellectual disabilities.
- Cigarettes: smaller babies than non-smokers; increased risk for premature birth and stillbirth.

- What are the symptoms of NAS?
  - Symptoms may vary depending on the type of substance used and the last time it was used. Symptoms of withdrawal may begin as early as 24-48 hours after birth or as late as five (5) to ten (10) days.
  - The following are the most common symptoms:
    - Tremors (trembling).
    - Irritability (excessive crying).
    - Sleep problems.
    - High-pitched crying.
    - Tight muscle tone.
    - Hyperactive reflexes.
    - Seizures.
    - Yawning, stuffy nose and sneezing.
    - Poor feeding and sucking.
    - Vomiting.
    - Diarrhea.
    - Dehydration.
    - Sweating.
    - Fever or unstable temperature.

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- How is NAS diagnosed?
    - An accurate report of the mother's drug usage is important, including the time of the last drug taken. A neonatal abstinence scoring system may be used to help diagnose and grade the severity of the withdrawal.
- How is NAS treated?
    - Babies suffering from withdrawal are irritable and often have a difficult time being comforted. Swaddling or snugly wrapping the baby in a blanket may help comfort the baby. Babies may also need extra calories because of their increased activity and may need a higher calorie formula. Intravenous fluids are sometimes needed if the baby becomes dehydrated or has severe vomiting or diarrhea.
    - Some babies may need medications to treat severe withdrawal symptoms, such as seizures and to help relieve the discomfort and problems of withdrawal. The treatment drug is usually in the same family of drugs as the substances the baby is withdrawing from. Once the signs of withdrawal are controlled, the dosage is gradually decreased to help wean the baby off the drug.

For additional information regarding NAS, see the Child Welfare Information Gateway.

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10.11 Appendix C: Screening Tools Used with Pregnant or Postpartum Mothers

10.11.1 DBHDS screening resource

There are numerous screening instruments that can be used with pregnant and child bearing age women. For more information see the DBHDS website.

10.11.2 The 4 P's

The 4Ps (Parents, Partners, Past and Pregnancy) was developed for use with pregnant women and women of child bearing age. This screening device is often used as a way to begin discussion about drug and alcohol use. Any woman who answers yes to one or more questions should be referred for further assessment.

1. Have you ever used drugs or alcohol during this **PREGNANCY**?
    a. Yes
    b. No
2. Have you had a problem with drugs or alcohol in the **PAST**?
    a. Yes
    b. No
3. Does your **PARTNER** have a problem with drugs or alcohol?
    a. Yes
    b. No
4. Do you consider one of your **PARENTS** to be an addict or alcoholic?
    a. Yes
    b. No

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10.11.3 The 5 Ps

The 5Ps was adapted by the Massachusetts Institute for Health and Recovery in 1999 from Dr. Hope Ewing's 4Ps (1990). This screening instrument is actually six (6) questions. It is the 4Ps and an additional question on peers and on smoking.

Before asking the following questions, develop a comfortable rapport with the mother. Any woman who answers yes to one or more questions should be referred for further assessment.

1. Did any of your PARENTS have a problem with using alcohol or drugs?
    a. Yes
    b. No
    c. No answer
2. Do any of your friends (PEERS) have problems with drug or alcohol use?
    a. Yes
    b. No
    c. No answer
3. Does your PARTNER have a problem with drug or alcohol use?
    a. Yes
    b. No
    c. No answer
4. Before you were PREGNANT, how often did you drink beer, wine, wine coolers or liquor or use any kind of drug?
    a. Not at all
    b. Rarely
    c. Sometimes

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d. Frequently

e. No answer

5. In the PAST month, how often did you drink beer, wine, wine coolers or liquor or use any kind of drug?

   a. Not at all

   b. Rarely

   c. Sometimes

   d. Frequently

   e. No answer

6. How much did you SMOKE before you knew you were pregnant?

   a. Don't smoke

   b. ½ pack a day

   c. 1 pack a day

   d. 1-2 packs a day

   e. No answer

10.12 Appendix D: Sample Plan of Safe Care

PLAN OF SAFE CARE FOR MOTHER, OTHERS AND SUBSTANCE-EXPOSED INFANTS

A Plan of Safe Care is a guide developed by service providers with their clients to ensure mothers and others have the necessary resources to safely care for the unique challenges of an infant who is exposed to substances during pregnancy. Each woman and infant's needs vary.

A Plan of Safe Care should include input from all service providers involved in the mother and infant's care to promote the best health outcomes. Service Providers can include: OB/GYNs, Doctors, Nurse Practitioners, Midwives, Opioid Treatment Programs, Community Service Boards, Child Welfare Providers, Home Visitors, and Part C Early Intervention.

HEALTH CARE		
	Plan (include WHO, WHEN, WHERE)	Comments
Prenatal Medical Care (Mother)		
Medical Care Post-Natal (Mother/others)		
Medical Care Coverage for Mother (e.g. FAMIS, Medicaid, private insurance, etc.)		
Delivery Plan (e.g. location, transportation, personal needs, medication at birth, etc.)		
Other		
SUBSTANCE USE AND MENTAL HEALTH		
	Plan (include WHO, WHEN, WHERE)	Comments

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Mental Health Treatment		
Substance Use Assessment		
Substance Use Treatment		
Medication Assisted Treatment		
Other		
DAILY LIVING		
	Plan (include WHO, WHEN, WHERE)	Comments
Financial Supports		
Safe Housing		
Food		
Transportation		
Other		
CHILD NEEDS		
	Plan (include WHO, WHEN, WHERE)	Comments
Safe Sleep Practices		

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Post-discharge Supports		
Basic needs post-delivery (e.g. diapers, formula, clothing, crib, car seat, etc.)		
Breast Feeding (Y/N)		
Medical Care Coverage for Child (e.g. FAMIS, Medicaid, private insurance, etc.)		
Child Care		
Pediatric Care		
WIC		
Medical Home		
Other		
SUPPORTS		
	Plan (include WHO, WHEN, WHERE)	Comments
Family		

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Formal Support Systems (e.g. DBHDS, CSB, CSA, CPS, DSS, VDH, etc.)		
Information Sharing (Release of Information)		
Home Visiting Program		
Early Intervention (Part C)		

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10.13 Appendix E: Substance Exposed Infant Decision Tree

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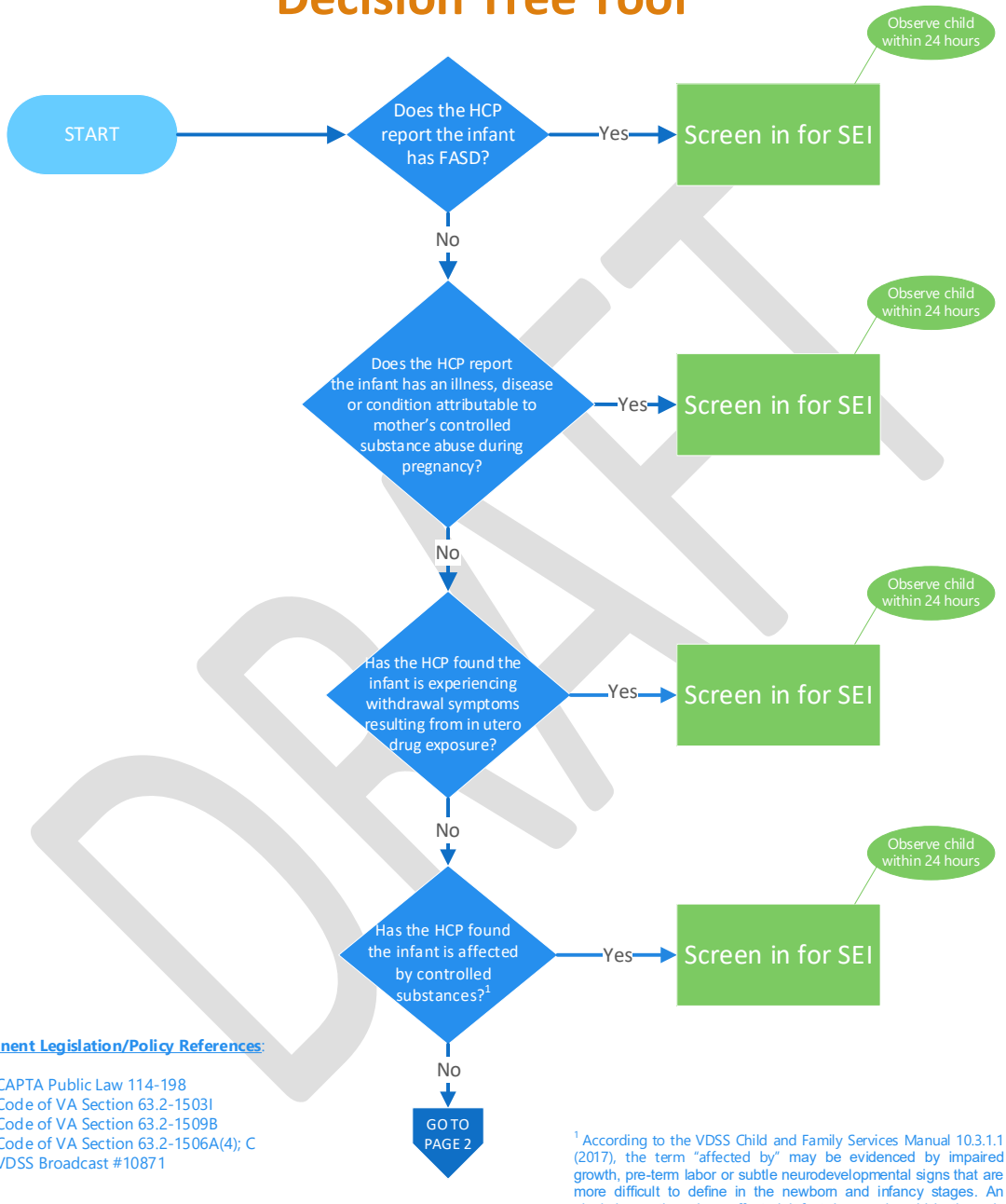
Substance-Exposed Infants (SEI) Decision Tree Tool



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Pertinent Legislation/Policy References:

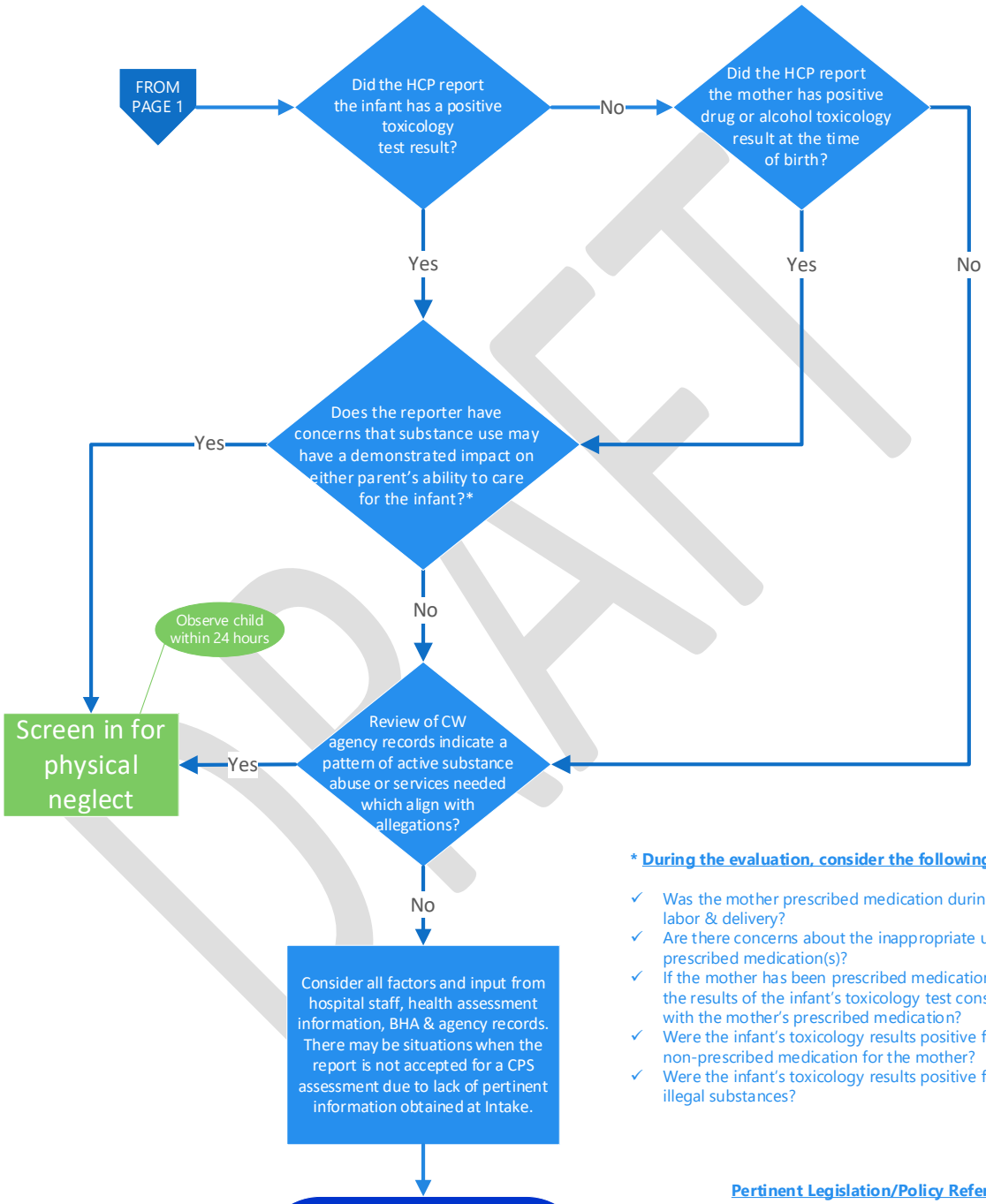
- CAPTA Public Law 114-198
- Code of VA Section 63.2-1503I
- Code of VA Section 63.2-1509B
- Code of VA Section 63.2-1506A(4); C
- VDSS Broadcast #10871

Acronyms:
FASD: Fetal Alcohol Spectrum Disorder
HCP: Health Care Professional

Rev Date: 7/19/18

[1] According to the VDSS Child and Family Services Manual 10.3.1.1 (2017), the term "affected by" may be evidenced by impaired growth, pre-term labor or subtle neurodevelopmental signs that are more difficult to define in the newborn and infancy stages. An alcohol or other drug affected infant is one in which there is detectable physical, developmental, cognitive or emotional delay or actual harm that is associated with parental substance use. The LDSS should collect and document how the child is affected by parental substance abuse.

SEI Decision Tree Tool (Page 2)



*** <u>During the evaluation, consider the following</u>:**

- ✓ Was the mother prescribed medication during labor & delivery?
- ✓ Are there concerns about the inappropriate use of prescribed medication(s)?
- ✓ If the mother has been prescribed medication, are the results of the infant's toxicology test consistent with the mother's prescribed medication?
- ✓ Were the infant's toxicology results positive for a non-prescribed medication for the mother?
- ✓ Were the infant's toxicology results positive for illegal substances?

<u>Acronyms:</u>
<u>CAPTA</u>: Child Abuse Prevention and Treatment Act
<u>CW</u>: Child Welfare
<u>HCP</u>: Health Care Professional

<u>Pertinent Legislation/Policy References</u>:

- CAPTA Public Law 114-198
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