

Child Protective Services Tasks Guide

Tennessee Department of Children's Services | February 2026

Table of Contents

Required Tasks on All Allegations 4

Meeting Priority Response 4

Notifying all Judicial Entities and Licensing Facilities of Case Initiation and Closure, Etc. 4

Contacting the Referent 4

Reviewing Family History 5

Conducting Home and Site Visits 7

Completing Assessment Tools 7

Identifying Safety, Risk, and Protective Factors 8

Requesting and Arranging Medical/Psychological Exams 9

Conducting Case Consultations 11

Completing Other CPS Assessment/Investigative Tasks 11

Receiving Additional Referrals on Open Cases 13

Monitoring and Assessing Progress 13

Classifying Allegations 14

Transitioning Cases 15

Closing Cases 16

Severe Abuse Allegations Tasks 18

Conducting Interviews 19

Key Components of Quality Interviews 19

Cultural Competency in Interviewing 20

Global Assessments in Interviews and Observations 21

Interviewing or Observing the Alleged Child Victim(s) 21

Minimal Facts 25

Observing Infants 26

Conducting Interviews with Children with Disabilities 27

Interviewing the Non-Offending Parent or Caregiver 28

Interviewing the AP, if they differ from the Parent/Caregiver 29

Interviewing or Observing other Children and/or Interviewing Other Adults Living in the Home....30
Interviewing Witnesses, Collaterals, and Other Professionals....31
Allegation Specific Tasks....31
Physical Abuse....31
Drug Exposed Child....40
Environmental Neglect....56
Nutritional Neglect....60
Medical Neglect....65
Educational Neglect....69
Lack of Supervision....76
Abandonment....80
Child Sexual Abuse....85
Sexual Harassment....104
Psychological Harm....107
Domestic Violence....110
Child Death/Near Death....123

Disclaimer: This guide is to be used as a support outlining possible case considerations related to the different abuse and neglect allegations CPS investigates. This guide is not meant to be used as a checklist as the tasks below may not be required in every case.

Required Tasks on All Allegations

Meeting Priority Response

1. Refer to Section B of DCS Policy *14.2 Screening, Priority Response and Assignment of Child Protective Services Cases* for detailed explanation of requirements on meeting the priority response on an assigned investigation.
2. In case the Child Protective Services (CPS) Case Manager cannot locate the child or family, the CPS Case Manager conducts at least two (2) good faith efforts (GFE's) per child which are defined as multiple, persistent, relevant attempts to locate the child within the identified response time. The CPS Case Manager, at a minimum makes one (1) or more visits to the alleged child victim's (ACV) residence, and goes to the school, childcare center or babysitter's home, or contacts one or more witness for additional information (refer to DCS Policy *14.4, CPS: Locating the Child and Family*).
3. If the alleged child victim is hospitalized, the CPS Case Manager or supervisor contacts the hospital, as per the requirements listed in the *Protocol for Working with Hospitals*.
4. If the referent is law enforcement or medical staff and is requesting immediate assistance, staff should respond immediately to the scene (or contact referent by phone if requested) after conferring with Team Leader, regardless of assigned response priority.

Notifying all Judicial Entities and Licensing Facilities of Case Initiation and Closure, Etc.

1. Each region must work with the local juvenile court judges and District Attorneys to establish standard operating procedures for notification for every child abuse and neglect referral and the summary of the results of the investigation.
2. If an investigation involves other agencies with investigative and/or licensure responsibilities (e.g., law enforcement, DMHSA licensed facilities, DHS daycare, DIDD, or DCS licensure), the applicable agency is notified, by the CPS Case Manager, no later than the next business day after consultation with the supervisor. The name of the agency and person notified is documented on the applicable screens in the Electronic Record System.
3. When DCS staff learn that the terms of a court order were violated, the Case Manager and/or supervisor notifies the Regional General Counsel (RGC)/designee.

Contacting the Referent

1. If the referent's name, address, email address, or telephone number are available, the CPS Case Manager makes sufficient efforts to contact him or her to verify information in the report and to obtain additional relevant information.
2. The referent will be able to track their referral through the Child Abuse Reporting and Tracking system. The assigned CPS Case Manager and their number is updated in this

system once the case is assigned. If the referent reaches out before the Case Manager has an opportunity to contact them, the Case Manager will return the communication promptly.

3. The assigned CPS Case Manager reviews the notification section on the assigned referral or searches the intake screen in the referent tab in the Electronic Record System, to determine if they must send a Confidential Notification Letter for Reporter. The CPS Case Manager is responsible for mailing the referent a letter when requested and noted on the referral.

Reviewing Family History

1. Conduct a DCS History Search

   a) The search function in Safe Measures is a quick way to gain a vast amount of information about a family. The searches can be completed by Case ID, Investigation ID, and Client ID. The most information is gained from a Client ID search; including CFTMs, FAST, Allegations and Classifications, and addresses associated with a client.

   b) The Electronic Record System Person Searches:

      - Start a search by SSN only.
      - Then with full name.
      - And finally full name with a DOB.

   c) Look at the variations of names (e.g., Bob, Bobby; Rob, Robby, Robert) the Electronic Record System collects for you. Also, when searching history on a woman, search by married, maiden, and even paramour names. The Electronic Record System uses phonetics to assist in retrieving names. It is helpful to spell names various ways, especially if the phonetics change (e.g., Mari, Marie, Mary).

   d) Completing a search of prior screened out referrals is another good way to gain some valuable insight into a family's history. Just because a call was screened out doesn't mean there was nothing to the allegation.

   e) It may also be helpful to search all the children and adults in the household, even those not on the referral, and be certain to at least glance the full list of names— not only the first page. You can also search for residential addresses without any name at all. When reviewing the Electronic Record System history, be sure to look for history in multiple disciplines (e.g., Family Support Services, CPS, Foster Care, and Juvenile Justice). Reach out to current CMs and touch base about your new case. Also, when you are short on time and reviewing CPS history, still always review the allegation/classification and intake. While reading more is best, this information will at least guide you to the allegations at hand and whether or not multiple referents are sharing similar concerns.

   f) If a match for the person is found, look at what allegations were involved and how they were classified, who were the ACV and AP in the prior cases, has the current AP been a victim previously, were there any services put into place and was the family compliant with the services.

   g) If a duplicate Person ID is found; email your region's Field Customer Care Representative

(FCCR) to request the duplicates be merged.

2. The CPS Case Manager also reviews the following types of information when applicable and available. The Sex Offender Registries must be checked for all adults in the home and all adults who supervise or have regular contact with the children. The other checks are at the discretion of the CPS Case Manager/Team Leader, unless required by another policy relevant to the case (IPA policy), and should be triggered by concerns present in the current case.

   a) Court records, Police records, local criminal history searches.

   b) Public records (utilities, rental information).

   c) Sex Offender Registries:

      - State Sex Offender Registry: *https://sor.tbi.tn.gov/home*
      - National Sex Offender Registry: *https://www.nsopw.gov/?AspxAutoDetectCookieSupport=1*

   d) State Drug Offender Registry: *https://apps.tn.gov/methor/*

   e) State Felony Offender Registry *https://apps.tn.gov/foil/*

   f) Medical Records (previous and current).

      - For infants born with and identified as being affected by substance abuse or experiencing signs of withdrawal, these records are required in order to address the health and substance use disorder treatment needs of the infant and in determining needed service referrals.
      - Medical records are vital to effective safety and risk assessment by providing information related to current and historical conditions. Medical records often affect the direction of investigations and the classification of allegations. Historical medical information may rule out possible abuse or neglect if a child has a chronic condition or illness that otherwise might suggest abuse or neglect.
      - These records may have relevance in court proceedings and future casework, so capturing these documents accurately in the electronic case record is critical.
      - Consult the regional DCS Nurse or the Regional Health Unit Nurse about the record and how the information may relate to your case.

        Note: Sometimes medical records are extremely large. Ask the regional DCS Nurse or the Regional Health Unit Nurse what pages would be best scanned into the Electronic Record System. They may be able to reduce 500 pages of records to the dozen pages most critical to your case.

      - Many medical providers will give you 2-sided records. Before scanning documents, ensure the scanning device (i.e., copier) is set to scan a 2-sided document. Consult your facilities and equipment manager if you need help.
      - Prior to uploading the documents to the Electronic Record System verify both sides of the page were scanned.

g) Educational Records.

h) Mental Health Records.

i) Community or Other Social Service Agencies.

j) Any other available and applicable records.

Conducting Home and Site Visits

1. The CPS Case Manager observes the home environment of the ACV (including second homes, if the ACV resides in two (2) locations), including all areas related to the allegations in the report and in compliance with standards of best practice. Obtain permission of an adult household member, and document in the Electronic Record System.
2. The overall environment must be described in the Electronic Record System, with details of any conditions that appear to pose a risk to the ACV's safety.
3. The CPS Case Manager should provide additional documentation through photographs and/or video. If a physical photograph is being utilized, the CPS Case Manager documents on the photograph the ACV's name, the date and time, address or location, and person taking the photographs and documents this information in the Electronic Record System. If the photograph is electronic, the same information will be added to the title of the photograph when uploaded to the Electronic Record System.
4. All case documentation is to be entered/uploaded to the Electronic Record System, as per DCS policy *31.14, Case Documentation Requirements*.
5. If the report or investigation suggests that the alleged abuse occurred in a setting other than the home (e.g., a day care center, park, school, etc.), the CPS Case Manager also visits the site to observe the setting and assess conditions that pose a risk to the ACV, and other potential victims.

   Note: The CPS Case Manager must obtain permission to enter the home. If permission to enter is denied, the CPS Case Manager will immediately consult with their supervisor regarding next steps. Additionally, the CPS Case Manager will document the denial in the Electronic Record System, including the name of the person who denied entry, as well as document any observations made while attempting to obtain permission to enter the home (i.e. what can be seen from the door and the outside of the home).

Completing Assessment Tools

1. The CPS Case Manager completes the Safety Assessment and/or Family Advocacy Support Tool (FAST), as applicable, within the required timeframes and practice requirements to support decisions related to safety, permanency, and well-being of the child. The CPS Case Manager refers to the Protocol for Completion of the Family Advocacy and Support Tool (FAST) for specific timeframes and expectations.

Identifying Safety, Risk, and Protective Factors

1. When conducting the assessment/investigation, the case manager may identify risks to children. When identified risks are associated with school personnel employees as alleged perpetrators, the below applies.

   a) CPS staff consults with legal before notifying the Superintendent or designee assigned to the school district where the allegation occurred.

   b) For School Personnel Only: Instances in which an emergency risk review determines the school personnel/alleged perpetrator poses a risk to the safety of children/youth, the assigned Team Coordinator, or designee, will provide notification to the Chief Officer of the local educational entity (e.g., Superintendent, Principal, or Headmaster) and State Board of Education via certified letter using the Pre-Substantiation Emergency Risk Notice (Letter Pre-3), found on the "O" drive. This notification will also be provided via email to the Director of the Due Process Procedures Unit.

   c) Below is a list of possible risk factors that **may** increase the likelihood of abuse and/or neglect:

      - Caregiver's substance use.
      - Caregiver's irrational thinking or other mental health issues, including depression.
      - Impaired or intoxicated caregiver.
      - Caregiver does not have an understanding of child development milestones or child's needs.
      - Increasing family stressors (e.g., loss of housing, employment, income; death in family; medical issues; birth of a child, etc.
      - Drug users, dealers, drug cooks, parolees, probationers, sex offenders, or other unknown people in/around residence.
      - Caregiver has out of proportion anger/rage or has impulsive, erratic, or aggressive behaviors.
      - Caregivers who are young, single parents, or parents with many children.
      - Caregiver was abused or neglect as a child.
      - Chaotic environment.
      - Multiple reports of abuse or neglect.
      - Child has behavior problems or is difficult to manage.
      - Weapons in residence.
      - Domestic violence in the residence.

   d) Additional factors that may increase the risk of abuse and/or neglect:

      - History of abuse/neglect – there is evidence of past maltreatment or a continuous pattern of abuse/neglect that threatens the health, safety, and/or development of

any child.

- Child factors – the child is vulnerable due to age, reduced visibility by others, health, intellectual or developmental level, problematic behavior, or there is difficulty in the parent-child relationship.
- Parent/Caretaker factors – the behaviors of a parent/caretaker present a threat of harm to the child and there is no evidence of sufficient family strength or protective factors to counter the behaviors.
- Environmental factors – there are significant problems in the home environment relating to child safety or isolation from family support systems.

e) Questions to consider regarding safety and risk:

- Is the family situation/condition out of control?
- Is this family situation/condition observable and can it be clearly described?
- Could this family situation/condition have a severe effect on a child?
- Is this severe effect imminent? (i.e., if it has not happened already, could it happen soon?)
- Are any of the children involved vulnerable? (age, disability, parentified [having responsibilities that are not age-appropriate]?)

f) Protective factors **may** lessen the likelihood of children being abused or neglected. Identifying and understanding protective factors are equally as important as researching risk factors. Protective factors include:

- Caregivers who create safe, positive relationships with children.
- Caregivers who practice nurturing parenting skills and provide emotional support.
- Caregivers who can meet basic needs of food, shelter, education, and health services.
- Caregivers who have a college degree or higher and have steady employment.
- Families with strong social support networks and stable, positive relationships with the people around them.
- Families where caregivers are present and interested in the child.
- Families where caregivers enforce household rules and engage in child monitoring.
- Families with caring adults outside the family who can serve as role models or mentors.

Requesting and Arranging Medical/Psychological Exams

1. The CPS Case Manager may submit a Case Service Request to arrange appropriate psychological and/or medical evaluations for any case participant to evaluate the existence and/or extent of physical or psychological harm or impairment. This evaluation is

appropriate if assessing potential risk of harm to the ACV or it provides information otherwise relevant to the investigation.

2. The cost of the psychological or medical evaluation can be covered by DCS by completing form CS-0533, Health Services Authorization for Non-TennCare Eligible.
3. If the parent/caregiver refuses to participate, the CPS Case Manager contacts the supervisor to discuss appropriate next steps, which could include consultation with legal staff to petition for Court intervention.
4. There are two (2) types of medical exams in CPS:
   a) Medical treatment exam: The purpose is to provide care for a child who is ill or injured.
      - If the CPS Case Manager conducting an investigation encounters an ACV who needs medical treatment, the CPS Case Manager asks the non-offending parent/caregiver to identify the ACV's physician, to make arrangements for the ACV to receive medical treatment, and ensures that the ACV has transportation to the appointment.

   b) Forensic medical exam: The purpose of the forensic medical exam is to assess the ACV's medical condition, obtain a diagnosis, determine if the ACV needs treatment, assess the ACV's risk of further harm, or aid in making a classification decision. The forensic medical evaluation is conducted by a competent practitioner with expertise necessary to assess the medical condition.
      - For guidance on sexual abuse cases, please see the Sex Abuse section of this manual.
      - For non-sexual abuse cases, the CPS Case Manager obtains a forensic medical evaluation when the case involves obvious severe injury/conditions, or when a medical opinion is needed to evaluate the injuries and the consistency of the explanation with the injury.

   c) To the extent possible, the CPS Case Manager works with the non-offending parent/caregiver to arrange this treatment or exam. The CPS Case Manager (in coordination with the supervisor if needed, and CPIT members when required), identifies the applicable practitioner to perform this exam, regardless of insurance coverage or TennCare eligibility.

   d) The practitioner who performs a forensic medical exam may or may not be the ACV's primary care provider. If the parents refuse to pay, have no insurance coverage, or there is no TennCare provided, the cost for the medical exam can be covered by DCS. Form CS-0533, Health Services Authorization for Non-TennCare Eligible must be completed for certain non-TennCare eligible children.

   e) If the parents are unable to transport the ACV, the CPS Case Manager may transport the ACV and the ACV's parent(s) to the appointment. The CPS Case Manager will not transport an ACV to a medical appointment without the written permission (CS-0827, Non-Custodial Consent for Transportation) of the parent/caregiver.

f) If the parent/caregiver transports the ACV, the CPS Case Manager may meet the family at the practitioner's office or clinic.

g) If the CPS Case Manager is unable to attend the medical appointment, s/he must contact the practitioner in advance to assure the identified concerns are addressed. The CPS Case Manager must also contact the practitioner after the ACV is treated for any findings are treatment recommendations, and to request a written copy of the medical report.

h) All medical/psychological reports are to be uploaded into the Electronic Record System and summarized in case recordings. Records that cannot be uploaded into the Electronic Record System should be maintained in a supplemental hard copy file.

Conducting Case Consultations

1. CPS Case Managers conduct regular case consultations as required by policy and needs of the investigations. Types of case consultations include:

   a) With the supervisor on all assessment/investigation cases as needed or required by Policy. Case consultations are documented in the Electronic Record System as an Administrative Review or within case approvals. (Refer to DCS Policy *4.4, Performance and Case Supervision Practice Guidelines and Criteria* for specific documentation requirements.)

   b) With regional legal counsel when required. The CPS Case Manager should document that the consultation occurred, but specific details of the consultation are not to be included.

   c) With the regional DCS Nurse for children with complex or serious medical needs when required. The CPS Case Manager should document in the Electronic Record System only that the consultation occurred; specific details of the consultation are not to be included. (Refer to DCS Policy *14.13, Non-Custodial Immediate Protection Agreements* and DCS Policy *14.14, Removal: Safety and Permanency Considerations*).

   d) With a Master of Social Work (MSW) or an individual with an advanced clinical degree to discuss minimizing trauma as a result of removing the child from the home.

Completing Other CPS Assessment/Investigative Tasks

1. The CPS Case Manager must establish all case participants in the Electronic Record System, to include the ACV(s), parents/caregivers, siblings, and other household members.
2. The CPS Case Manager may coordinate a Child and Family Team Meeting (CFTM) any time a CPS Case Manager or family member determines it would benefit the child and family or when:

   a) A child is entering state custody.

   b) A CS-0701, Immediate Protection Agreement is developed which includes voluntary

custodial interference.

c) An immediate harm factor has been identified that places the child at risk of an emergency removal into state custody

d) The outcome of the FAST process suggests immediate intervention is recommended or there are high risk factors identified with insufficient protective factors to assure the child's ongoing safety.

Note: The applicable RGC is notified immediately upon the team's decision to recommend custody or continued custody to a Juvenile Court Judge.

e) The meeting date, attendance and outcomes are documented in the Electronic Record System by the CPS Case Manager and/or CFTM Facilitator.

3. The CPS Case Manager must create a Non-Custodial Permanency Plan (NCPP) to include each family member with an identified need for services. The NCPP includes:

a) Agreed upon goals, desired outcomes, and timeframes for achieving them;

b) Services and supports to be provided, and by whom;

c) Timeframes for evaluating family progress; and

d) The signature of the parent(s) and the ACV, if age appropriate.

Note: For non-custodial and custodial cases, services are documented the Electronic Record System on the NCPP and/or CFTM Summary (Refer to DCS Policies *14.12, Family Permanency Planning for CPS Non-Custodial Cases* and *31.1, Family Permanency Plans*).

4. The CPS Case Manager must complete required forms and documents, and review with the family as applicable (see the list of required forms and documents in the Forms and Collateral Documents sections of CPS Chapter 14 Policies and Procedures).

5. The CPS Case Manager must maintain regular contact with community partners and service providers. Document follow-up conversations regarding any additional tasks to be completed or progress/barriers with service delivery.

6. The CPS Case Manager must make a referral to Tennessee Early Intervention Services (TEIS) for substantiated cases involving children under the age of three (3), or cases classified as Services Needed or Services Needed/Court Ordered by:

a) Calling 1-800-852-7157, a toll-free telephone number dedicated by the Department of Disability and Aging online at Tennessee Early Intervention System (TEIS), and completing DCS form CS-0811, Tennessee Early Intervention System (TEIS) Referral to provide the requested information below:

- The ACV's name, date of birth and contact information;
- The biological and/or custodial parent's name and contact information;
- The foster parent's name and contact information, when applicable; and
- The CPS Case Manager's name and contact information.

b) Notifying the ACV's parents/non-custodial caregiver or foster parents of the referral and documenting in the Electronic Record System that the referral was made.

Receiving Additional Referrals on Open Cases

1. When an additional allegation(s) has been reported and added to an already open Assessment case, the CPS Case Manager conducts case activities in accordance with this guide in an effort to address the additional concerns. The CPS Case Manager documents the addition of the new allegation(s) in the Electronic Record System and consults with the supervisor.
   a) Additional allegations may be added to an already open case when:
      - The additional allegations would be assigned to the Assessment track; and
      - The already open Assessment case does not have an approved classification.
   b) If new severe abuse allegations are called in and there is a current open Assessment case, a new Investigation case will be opened and assigned to the Investigations team.
2. If there is an open Human Trafficking, Severe Abuse, or Drug Team case when the new allegations are called in, the new referral will be added to that team's Case Manager's open case.

Monitoring and Assessing Progress

1. Monitoring and tracking the family's progress should begin as soon as the intervention is implemented and throughout the life of the case until targeted outcomes are complete. Case Managers should evaluate progress by doing the following:
   a) Engage the family and children in reviewing progress - Family should be asked about their perception of progress.
   b) Engage service providers frequently to provide one another updates on the family's progress.
2. To analyze the family's progress, one can ask the following:
   a) Is the child safe?
   b) Have protective factors or safety factors changed?
   c) What changes have occurred in the factors that contribute to the risk of neglect?
   d) What progress has been made toward achieving the case goals and outcomes?
   e) What is the current level of risk in the family?
   f) How effective have the services been in achieving the outcomes and goals?
   g) Have services been provided to the family in a timely manner?
   h) Has the family participated in services as scheduled?

i) Has the service provider developed a rapport with the family?

j) Is there a need to alter the plan of service based on changes in the family?

k) What is the current level of risk in the family? Is there potential for additional court involvement or review?

Classifying Allegations

All allegations are classified within 45 (forty-five) calendar days from the date of intake.

1. Each non-severe allegation is classified at the discretion of DCS according to one of the following categories (Refer to DCS Policy *14.6, Child Protective Services Case Tasks and Responsibilities*):

   a) No Services Needed;

   b) Services Recommended;

   c) Services Needed;

   d) Services Needed, Court Ordered;

   e) Unable to Complete; or

   f) Administrative Closure.

2. Severe cases may have extenuating circumstances that prevent a classification decision from being made (i.e., results of an autopsy outstanding, at the request of law enforcement, etc.) within 45 (forty-five) calendar days, and these reasons must be documented in the Electronic Record System. Each severe allegation is classified at the discretion of DCS according to one of the following categories (Refer to DCS Policy *14.6, Child Protective Services Case Tasks and Responsibilities*):

   a) Allegation Substantiated, Perpetrator Substantiated;

   b) Allegation Substantiated, Perpetrator Unsubstantiated;

   c) Allegation Substantiated, Perpetrator Unknown;

   d) Allegation Unsubstantiated, Perpetrator Unsubstantiated;

   e) Allegation Unsubstantiated, Children with Sexual Behavior Problems;

   f) Unable to Complete; or

   g) Administrative Closure.

   Note: Regardless of classification, including Unable to Complete and Administrative Closure, all cases must be presented to CPIT.

3. An allegation and/or AP may be substantiated based on a preponderance of evidence and on proof of one or more of the following factors (also known as validation criteria), linking the abusive or neglectful act(s) to the AP (Refer to DCS Policy *14.6, Child Protective Services Case Tasks and Responsibilities*):

a) The ACV's statement that the abuse or neglect occurred;

b) Medical and/or psychological information from a licensed physician, or other treatment professional that corroborates that the child abuse or neglect occurred;

c) An admission by the AP;

d) Information (written or verbal) gathered from credible witness(es) and/or collaterals regarding the abusive or neglectful acts;

e) Circumstantial evidence linking the AP to the abusive or neglectful act(s), including the opportunity for the alleged abuse to have occurred (e.g., ACV was in the care of the AP at the time the abuse occurred and no other reasonable explanation of the cause of the abuse exists in the record, etc.);

f) Physiological indicators or signs of abuse or neglect including, but not limited to, cuts, bruises, burns, broken bones or medically diagnosed physical conditions;

g) Physical evidence discovered that corroborates the allegation of abuse or neglect;

h) The existence of behavioral patterns that may indicate or corroborate the allegation of abuse or neglect.

Transitioning Cases

1. Case transition occurs when it is determined that a service need is identified for a non-custodial case or when custodial services are required.

   a) If service needs are identified for a family prior to case closure and there is a need for continued assistance/monitoring or completion of action steps following the closure of a non-custodial CPS case, a transfer may be initiated for in-home case management, as per DCS policy *14.18, Family Support Services Program* and the *Protocol for Family Support Services*. Once determined by the CPS Case Manager and supervisor, the CPS Case Manager:

      - Will meet with the assigned FSS Case Manager within five (5) business days to review service needs and plan next steps for transition. This meeting should also focus on:
        - Sharing information related to the reason for involvement including safety concerns and risk factors;
        - The level of cooperation from the family;
        - Any results from the formal and informal assessments; and
        - Interventions attempted and the effectiveness of those interventions.
      - Schedules a transfer CFTM to be held prior to case closure. The transfer CFTM should include the family, FSS worker, CPS Case Manager, supervisor or designee, providers, and any support persons identified by the family, as applicable

        Note: a skilled facilitator is not required for this meeting).
        - Families and agency partners should be notified of the date and time of the

meeting no less than ten (10) calendar days in advance, in writing, or no less than seven (7) calendar days in advance, by telephone, email, or face-to-face. The method of notification for each invitee shall be documented in the Electronic Record System in the CFTM section of the family case.

- Completes, prior to the transition CFTM and before final case transfer, the following activities from form CS-1031, CPS Case Transition Checklist:
  - The Family Permanency Plan;
  - Initiates or update the FAST; and
  - Update the case service request (CSR), when applicable, for purchased services which are to continue.
- Updates documentation in the applicable sections of the Electronic Record System to include details of the transfer CFTM, addresses, telephone numbers, and relationships in the family case for all case members.

b) When a case is transitioned to custodial services, the CPS Case Manager:

- Is responsible for formally transitioning the case to a Family Services Worker (FSW);
- Updates the Electronic Record System, as per DCS policy *31.14, Case Documentation Requirements*. (Refer to DCS Policy *14.15, Confidentiality of Child Protective Services Cases*);
- Will schedule a pre-custodial CFTM, if possible, and invite the assigned FSW.
- Contacts the FSW, in non-emergency removals, prior to placing the child into the state's custody to case conference and share information;
- Contacts the FSW or Custodial Supervisor, in emergency removals, to case conference and share information in accordance with standard operating procedures dictating case assignment; and
- Attends the initial CFTM, when possible and applicable, in accordance the Child and Family Team Meeting Guide.

Closing Cases

1. To close a CPS case, all CPS responsibilities from DCS Policy *14.6, Child Protective Services Case Tasks and Responsibilities* and the *Protocol for Child Protective Services Case Tasks and Responsibilities*, and this guide must be completed within sixty (60) or ninety (90) calendar days. Documentation of these tasks should include:

   a) Complete case recordings that include all of the following for each contact:

   - Date and time of contact;
   - Type of contact (i.e., home visit, office visit, telephone conversation, written correspondence).
   - Name of all person(s) involved in the contact and their relationship to ACV;

- Name of the DCS employee making contact;
- Names of all persons present during contact;
- Purpose of the contact;
- Summary of the substance of the contact, including;
  - Issues discussed and clients' response to those issues
  - Details of the interactions, discussions, agreements and/or decisions made
  - Observations and discussions of safety and risk factors
  - Observations of child and family including, but not limited to, specific observable behaviors witnessed, wellness of those interviewed, any intellectual or developmental concerns, and any identified medical or mental health needs
  - Any other corroborating evidence to support the classification
  - Next steps to be taken and by whom
  - Conversation with the family about case closure and classification;

    Note: Case recording narratives must contain case relevant information and must be written in clear and complete sentences. They should not contain slang language, subjective or personal value judgements or administrative activities (e.g., Case Manager is out on leave). Case recordings may contain a summary of information provided in emails or text messages. This type of correspondence may be uploaded into the Electronic Record System. Emails and/or text messages should never be copied into case recordings.

2. Complete a closing FAST, including the safety section.
3. Refer to DCS Policy *20.28, Child Death and Near-Death Response and Review* for child death/preliminary near-death cases which require additional tasks.
4. Complete form CS-0740, Child Protective Services Investigation Summary and Classification Decision of Child Abuse/Neglect Referral that documents the classification decision.
5. Document a closing case summary in the Electronic Record System.
6. Submit the case to the supervisor for closure. The supervisor's approval indicates:
   a) All documentation is complete;
   b) All information and decisions have been reviewed;
   c) All collaborative service providers have been informed of case closure; and
   d) All notifications have been made.
7. If an investigation goes beyond 60 (sixty) calendar days, the supervisor documents, in an Administrative Review, an explanation for the delay and a plan for completing the case (Refer to DCS Policy *4.4, Performance and Case Supervision Practice Guidelines and Criteria*).
8. The CPS Case Manager ensures that all demographic information has been entered into the

Electronic Record System for all ACVs and APs. APs that have been substantiated must have an updated address for Due Process notification purposes.

9. If the substantiated perpetrator is a minor, the name and address of the minor AP's parent/legal guardian must be entered in the 'In Care Of' field in the Electronic Record System for Due Process Notification purposes.
10. If, at the conclusion of an investigation, the CPS Case Manager feels that a person has either verbally or by written or printed communication knowingly and maliciously reported, or caused, encouraged, aided, counseled, or procured another to report a false accusation of child sexual abuse or abuse/neglect that has resulted in a wound, injury, disability, physical, or mental condition, the CPS Case Manager consults with the RGC. This consultation should include discussion surrounding the intention behind the allegation reported and if it is likely that the reporter knew, at the time of making the allegation, that it was false. After a determination has been made concerning whether malicious false allegations have been reported, the CPS Case Manager or RGC can refer to the local District Attorney's office.

Severe Abuse Allegations Tasks

1. All severe abuse investigative activities are completed by the Case Manager assigned to the case and/or CPIT team members.
2. The Child Protective Investigative Team (CPIT) must be convened immediately (no later than twenty-four (24) hours from) when a report of severe abuse/neglect (including child sexual abuse) has been received or identified at some point during the life of a CPS case.
    a) To convene CPIT, DCS contacts CPIT members according to standard operating procedure, and gives notification of a report of child sexual abuse or severe abuse. CPIT members include the District Attorney, Law Enforcement, Child Advocacy Center, Juvenile Court, and may also include a Mental Health Representative, Medical Professional, and/or Anti-Trafficking team.
    b) Convening CPIT does not meet the priority response timeframe assigned to the case.
3. Consultations with CPIT members are documented in the Electronic Record System.
4. All CPIT notifications must be documented in the case recordings and include full names and titles of parties contacted (refer to DCS Policy *14.7, Multi-Disciplinary Team: Child Protection Investigation Team*).
5. In all investigations involving CPIT, the interview of an alleged perpetrator (AP) must be coordinated with law enforcement, as per applicable Memorandums of Understanding.
6. When law enforcement assumes responsibility for interviewing an AP but fails to conduct an interview within forty-five (45) days of the date of the report, the CPS Case Manager proceeds to conduct the interview, after notifying the law enforcement officer responsible. The CPS Case Manager documents this notification and interview in the Electronic Record System.

7. When law enforcement assumes responsibility for the interview of an AP, the CPS Case Manager makes every effort to access adequate documentation of the content of the interview.
8. When law enforcement does not provide access to their investigative information, the CPS Case Manager contacts their supervisor, to determine if there should be an additional interview with the AP. The CPS Case Manager should communicate with Law Enforcement on any additional steps they must take. These consultations are documented in the Electronic Record System.
9. Upon identification of possible human trafficking, refer to DCS Policy *31.10, Combatting Commercial Sexual Exploitation of Minors* for immediate notification and assessment of all ACV's identified as experiencing CSEM.
10. Case Managers should obtain a forensic medical evaluation when the case involves obvious severe injury/conditions, or when a medical opinion is needed to evaluate the injuries and the consistency of the explanation with the injury.
11. The outcomes of CPIT Case Reviews are to be documented in the Electronic Record System and the form, CS-0561, Child Protective Investigative Team Review, is uploaded into the Electronic Record System.
12. Additional recommended tasks as needed:
    a) Refer children and/or parents and caretakers for psychological evaluations and any other assessments or services deemed necessary.
    b) Consult with regional DCS Nurse, Psychologists, Educational Specialist, etc.
    c) Conduct other records checks (educational, mental health, community/social services agency)

Conducting Interviews

Key Components of Quality Interviews

1. Use each interview to identify corroborating statements or inconsistent stories. Do not immediately make a conclusion of what happened, allow the facts to determine the outcome.
2. Structure of an interview
    a) Introductions
        - Provide interviewers name and explain your role in the family's case
        - Explain the purpose of CPS contact with the child/family
        - Carefully choose the location/setting of interviews
        - Explain the investigative process
    b) Engagement and Rapport

c) Complete a global assessment while assessing safety and risk

d) Transition to allegation concerns

e) Allow for discussion of topics/issues/concerns the interviewee feels are important, including topics not previously addressed

f) Attempt to transition to a discussion of neutral topics prior to ending the interview. You can also talk about what they are doing well within the home

g) Provide thanks for their participation in the interview and conclude the visit.

3. The interviewer should use discretion in selecting questions to elicit accurate information. Interviewers should move from open-ended to more focused questions to gather clarifying information and then move back to open-ended questions. Phrase your questions in a manner that is not accusatory.

   a) Open-ended—Open-ended questions can prompt a free narrative response.

      - Tell me everything from beginning to end.
      - What happened next?
      - Then what happened?
      - You said X happened—tell me more about X.

   b) Closed-ended—Closed-ended questions, such as yes/no questions, clarify a response or information already provided. Closed-ended questions should be used sparingly.

      - Is someone worried about you?

   c) Suggestive and leading questions should not be used.

Cultural Competency in Interviewing

1. The families we serve come from many cultural, ethnic, and religious backgrounds. As CPS Case Managers, we need to be prepared and willing to work with all of them. Strategies for engaging someone where there are differences in diversity:

   a) Ask if they would feel more comfortable with a translator if there is a language barrier (Even if they speak some English, they may feel more comfortable with a translator present in case there are difficult words they don't understand. Be cognizant of abbreviations and difficult words or talking too fast)

   b) For adolescents and teens present yourself as a learner (Ask them how they identify. Don't make assumptions. Ask them about their experiences or what their culture/identity means to them).

   c) Take time to do some research on the culture (Taking a little bit of time to research about a point of diversity can do a lot to improve rapport building and a global assessment).

   d) Consider what gestures or actions may be considered respectful or disrespectful to a

different culture.

Global Assessments in Interviews and Observations

1. Global assessments are to be done with every member of the child's household, including child(ren). Some topics may not be suitable for all ages of children, but every effort should be made to assess, using age-appropriate questions, all areas listed below. Consider using the FAST questions as an ice breaker since some of the topics are the same. This is not to be a checklist completed with the family, but a conversation about each topic.
    a) Discuss members of the household and their relationship to the child(ren), including split custody arrangements and visitation.
    b) Explore each household members' responsibilities.
    c) Assess the family's discipline practices (each child should be asked, consider that not all children within the family are disciplined the same).
    d) Assess for basic needs including housing, sleeping arrangements, utilities, and access to food.
    e) Assess health (health insurance, name of doctor, name of prescribed medication, diagnoses, etc.)
    f) Assess education (for children - name of school, attendance, child's feelings about school; for adults – level of education completed)
    g) Assess for past trauma (Is there anything that still bothers you on a day-to-day basis from your past? How does it affect you now?)
    h) Explore a history of domestic violence (How does the family deal with and/or resolve conflict?)
    i) Assess the overall physical appearance and absence or presence of injuries.
    j) Assess for any signs of developmental concerns or disability.
    k) Explore supervision responsibilities for children within the household.
    l) Assess for knowledge of drug activity.
    m) Assess for sexual abuse (body safety questions - knowledge of private parts and what would be done if something happened to their private parts)
    n) Discuss safety in general with the child and what it means to be safe, including any safety factors the child may share.

Interviewing or Observing the Alleged Child Victim(s)

1. Regardless of circumstances or initial conclusions, CPS will make every effort to interview the alleged child victim, as well as all children who live in a household, privately at each visit to assess for safety. Interviews are often best conducted in a setting outside the home, such

as school, a relative's home, or daycare. Interviewing a child about abuse or neglect in their home may be difficult, as the home environment itself may be inciting and too traumatic a location for disclosure. A child may also fear someone else in the home overhearing, even if you, as the adult, logically know this is impossible (e.g., because parents are outside, etc.).

2. Some tips for interviewing children:
    a) Position yourself on their eye level. This may mean sitting on the floor or in a children's chair.
    b) Demonstrate genuine interest in the child by maintaining eye contact, being responsive and asking genuine questions about the child and their interests.
    c) Describe what you do in a child-friendly way.
    d) Be relaxed and start with some easy/fun questions.
    e) Give the child an opportunity to ask you questions.
    f) Consider a child's developmental age in how you interview. Some children do great being asked to draw a picture of their family, then describe what they drew, and what each person is like.
    g) Rapport building provides a great opportunity to gauge what types of questions the child may be able to answer, or is willing to answer.
    h) Phrase questions in a developmentally appropriate way.
    i) Do not use suggestive or leading questions.
    j) Be empathetic and non-judgmental. Focus on understanding the child’s real feelings.
    k) Keep your tone, facial expressions, and body language neutral and avoid over-reacting.
    l) Allow silence.
3. Things to assess for in the ACV interview:
    a) The child’s characteristics (e.g., age, developmental level, physical appearance, health, mental health status)
    b) The child’s behavior and feelings
    c) The child’s relationship with peers, extended family, or significant persons
    d) The child’s daily routine (e.g., school, childcare, clubs, home life, other)
    e) Description of allegation, when/where it occurred, who was present
    f) The child’s current condition
    g) Identify supports or collaterals
4. Questions to explore safety:
    a) Do you know what it means to be safe? If yes, have the child give you an example of what ‘safe’ means to them. If no, CPS Case Manager must define ‘safe’ with the child.)
    b) Do you feel safe at home?

c) Do your parents argue in front of you? How does that make you feel?

d) Has there ever been a time you were scared when your parents were arguing?

e) Have you ever been picked on or bullied? What happened and did you tell anyone?

f) Have you gotten into fights at school trying to defend yourself or with kids in your neighborhood?

g) Anything worry you or make you scared?

h) Explore body safety, talk about parts of the body it's not ok for other people to touch (get them to point and provide the name for that body part).

Note: The body safety questions are to be asked with every child in every case, as part of the global assessment, regardless of allegation type.

i) Has anyone ever touched your …… (call it by the name they provided)? Has anyone ever asked you to touch their…….?

j) Do you have a cell phone? Has anyone ever sent you a picture of their …… (private part) or asked you to send them a picture of your …. (private part)? If they respond yes, who sent it and when was it sent?

k) Is there someone they trust and can go to when in trouble or scared?

5. Questions to explore the home environment:

a) Who do you live with or who lives at home with you? Do you have your own room?

b) If child provides names of brothers and sisters, do you know how old they are asking each child's name they provided.

c) Is anyone else living in your home?

d) Does your mom and dad work, if yes, what do they do and where do they work?

e) Do you have chores at home, what are they if answer is yes?

f) What happens if you don't do your chores or what is asked of you?

g) Do you get along with your parents, your siblings?

h) What kinds of things do you and your family argue or disagree about? What happens when everyone doesn't get along?

i) What do you and your family do for fun?

6. Questions to explore their education/schooling:

a) Which school do you go to? What grade are you in?

b) What do you like best and least about school? Favorite subjects? Worst subjects?

c) What kind of grades do you make? Is there one subject you are struggling in and wish you had more help in?

d) Do you play sports? If yes, ask what position they play and how long have they played (football, baseball, basketball, soccer, and or tennis).?

e) What do you want to be when you grow up and finish school? Any future plans/goals (depending on age of child)?

f) How do you get along with your teachers, do you have a favorite teacher?

g) Have you gotten in trouble at school? If yes, what happened?

h) How do you get along with your friends/peers? Inquire about "bullying".

7. Questions to explore their activities:

a) What do you do for fun after school or on weekends?

b) Who do you mostly hang out with?

c) Do you spend time with your family? What do you do with your family for fun?

d) What are your favorite TV shows or video game to watch or play?

e) What is your favorite type of music? What is your favorite song, group/band?

8. Questions to explore mental health:

a) Do you take medication for anything?

b) Do you feel stress or anxious about things more so now than before?

c) Do you worry a lot? If yes, what do you worry about?

d) Are you having trouble sleeping?

e) Have you had thoughts about hurting yourself or wishing that you didn't exist?

f) Tell me about a time when someone picked on you or made you feel sad or uncomfortable.

g) Does it seem that you have lost interest in things that you used to really enjoy? Can you tell me more about that?

h) Do you find yourself spending less time with friends and people you care about?

i) Would you rather just be by yourself most of the time? Is this something different or have you always liked to be by yourself?

j) Have you ever tried to hurt yourself, or planned to hurt yourself but didn't follow through?

k) What do you do to relieve the pain and hurt you are feeling?

9. The initial ACV interview must occur within the timeframe required by the assigned priority response or within such timeframe as determined by CPIT. Reasonable concerns about the ACV's safety must outweigh any other consideration of the timing and location of an interview.

10. A minimum of one monthly face to face contact each calendar month is required with each ACV for the duration of the open CPS case. The CPS Case Manager is to assess for safety and risk during every contact with the child.

11. The ACV's interview or observation is a face-to-face contact with the ACV for the purpose of

asking questions concerning the allegations and observing the ACV's physical/emotional condition. The content of the interview and all observations are documented in the Electronic Record System.

12. When necessary (and when it does not interfere with the integrity of the investigation), the CPS Case Manager notifies the non-offending parent/caregiver of the ACV's interview prior to the interview or, if not possible, immediately following the ACV's interview. If the parent/caregiver cannot be notified, or if it is not reasonable to do so, efforts and/or reasons should be documented in the Electronic Record System.
13. If the ACV does not communicate verbally and when communication is not possible with the CPS Case Manager, the CPS Case Manager must observe the child's physical condition and behavior, relative to the allegations and best practice standards, and specifically document these observations in the Electronic Record System.
14. Every effort must be made for the interview and observation of the ACV to occur away from the AP.
15. If immediate harm factors are present, as determined by formal and informal assessments, a safety intervention must be considered, including the use of an Immediate Protection Agreement (IPA). The IPA must be discussed with and approved by the supervisor in consultation with the applicable RGC. In no case is a child left at risk while these discussions are being held. Form CS-0701, Immediate Protection Agreement must be completed and each immediate harm factor identified, unless protective custody is immediately necessary (Refer to DCS Policy *14.13, Non-Custodial Immediate Protection Agreements*).
16. If the ACV's parent/caregiver refuses to allow him or her to be interviewed or observed, the CPS Case Manager immediately notifies the supervisor, who immediately consults with applicable RGC. These notifications and consultations (without providing the content of consultations) must be documented in the Electronic Record System.

Minimal Facts

1. "Minimal facts" interviews are conducted by case managers in an effort to avoid unnecessary multiple interviews of alleged child victims (ACVs). The minimal facts interview is an initial, basic, fact-finding interview, used to help determine initial safety decisions. **Minimal facts interviews are not needed on every sex abuse case.** Even if an ACV does not initially disclose abuse, it is possible a forensic interview is needed.
2. When possible, all minimal facts interviews must be conducted in a neutral, safe environment (separate from where the alleged abuse occurred).
3. Interview Structure:
    a) Introduction (you and your role today): Name, Profession (in child's terms), "I talk to kids about things that have happened to them."
    b) Rapport: Talk about everyday things and topics that interest the child, show interest in what child has to say.

c) Transition to the allegation concern (use vague, open-ended questions);

- Do you know why am I here today?
- What did your mom/Dad/teacher (whomever brought them to you) say about us talking today?
- Have you told anyone that something happened to you?
- I heard that someone is worried that something may have happened.

d) Limited questioning - Confirm WHO, WHEN, WHERE:

- WHO the alleged perpetrator is (Confirms relationship criteria)?
- WHEN the last incident happened (confirms whether a medical is needed as soon as possible)
- WHEN the alleged perpetrator will next have contact with ACV (for safety planning purposes)
- WHERE (confirms the jurisdiction for law enforcement)
- Do not ask for specifics details regarding type of touch, number of times, or any other details of the incident (that is for the forensic interview).
- It is okay to ask if the victim knows if this has happened to anyone else

e) Transition to explaining next steps. Set the stage for the forensic interview:

- What you're saying is very important. I'd like you to talk to someone else about this somewhere where you can be more comfortable. Is that okay?"

f) Thank the child: "Thank you for talking with me and it was very brave of you."

Observing Infants

1. The infant should be observed awake without external distractions. The observation should include:
   a) Physical appearance: physical condition of the baby (skin, eyes, etc.)
   b) Infant needs to be undressed to full observe (maybe asking parents to change the infant's diaper)
   c) Review Safe Sleep for all children under age one year (review and get form CS-1209, Safe Sleep Assessment, signed) at initial visit and observe where the children sleep. If family does not have appropriate place for a baby to sleep, what steps can be taken to ensure safe sleep is being followed in the home?
   d) Breathing: Does it appear normal or labored?
   e) Is the infant average size for their age?
   f) Does the baby move all four limbs?

g) How alert is the baby?

h) Any obvious disabilities observed?

i) How does the baby smell?

j) Does the baby cry, smile, laugh?

k) Are their clothes clean?

l) How do the caregiver and baby interact?

m) Is the baby responsive to the caregiver?

n) Does the baby react to toys and other objects as age appropriate?

o) Is the baby socially responsive?

p) Is the baby easy to console?

q) Are there items present necessary to care for an infant?

r) Are milestones being met?

Conducting Interviews with Children with Disabilities

1. Prior to conducting an interview, including the Initial ACV interview, the CPS Case Manager determines whether the child is able to effectively communicate by contacting a non-offending family member and/or professional partner such as 1:1 aides, occupational therapists, physical therapists, behaviorists, speech therapists, and/or nurses with knowledge of the child's ability to communicate unless the immediate safety of the child would be compromised.
2. For school-aged children, the CPS Case Manager contacts the child's teacher and/or school administrator to determine the child's verbal skills and applicable methods of interview.

   Note: Even if the initial contact has occurred, professional partners are to be contacted as collaterals.
3. The CPS Case Manager obtains and reviews copies of any documentation of services provided to the child such as Individual Education Plan (IEP) or Section 504 Plan within the school system, Individual Service Plan with the Department of Intellectual and Developmental Disabilities, and/or any other service providers.
4. If alternative forms of communication are identified to better obtain information from the child, the CPS Case Manager coordinates with speech services such as speech therapist(s), speech pathologist(s) and/or special educator(s) or staff to assist/interpret in the interview process. The CPS Case Manager has the assisting professional sign form CS-1226, Confidentiality Agreement for CPS for CPS Interviews.

   Note: The CPS Case Manager must evaluate the ability of the assisting/interpreting professional to remain unbiased in translation of the child's communication with the CPS Case Manager prior to and during the interview.

5. The CPS Case Manager begins the interview through establishing meaningful rapport and developing a baseline to:
    a) Create a relaxed, supportive environment that reduces anxiety and establishes trust;
    b) Identify strengths;
    c) Identify any cognitive and/or social needs; and/or
    d) Assess the child's mode of communication.

    Note: If the CPS Case Manager receives reports of the child being non-verbal or non-communicative, they will still attempt to interview and/or observe the child to assess for safety and risk factors.

Interviewing the Non-Offending Parent or Caregiver

1. It is highly recommended that the interview with the non-offending parent/caregiver occur on the same day the ACV is interviewed. If this is not possible, efforts and/or reasons should be documented. The parent/caregiver interview must be fully documented in the Electronic Record System.
2. The CPS Case Manager or CPIT member(s) interviews the ACV's non-offending parents or caregiver. If a CPIT member conducts this interview, the CPS Case Manager should also be in attendance. The CPS Case Manager must obtain information from the interviewer to construct adequate documentation of the process and content of the interview.
3. During the initial contact with the parent/caregiver/family involved in the CPS report, the CPS Case Manager informs each non-offending parent/caregiver of the allegations under investigation and the CPS process, as well as their rights and responsibilities (Clients Rights Handbook). Form CS-0050, Case Intake Packet Documents and Native American Heritage Verification is signed by the parent/caregiver acknowledging receipt of the handbook.
4. The CPS Case Manager should also work to gather information about relatives, friends, and significant kin that could provide resources or potential placement opportunities. This information should be documented in the Electronic Record System.
5. During the initial contact, the CPS Case Manager also inquires if there is any Native American lineage or ancestry that might make the child/family eligible for membership in any Native American Tribe. If the family confirms that they do have Native American lineage, conduct the investigation according to DCS Policy *14.6, Child Protective Services Case Tasks and Responsibilities* and the *Protocol for Child Protective Services Case Tasks and Responsibilities*, and follow instructions as outlined in DCS Policy *16.24, Children of Native American Heritage* and the *Protocol for Work with Children of Indian Heritage* to comply with the Indian Child Welfare Act of 1978 (ICWA) guidelines. Efforts to identify the tribe and notifications made to the Bureau of Indian Affairs must be documented in the Electronic Record System. To document that an inquiry was made and that no Native American heritage exists, CS-0050, Case Intake Packet Documents and Native American Heritage Verification must be completed, as well as any other required forms.

6. If the parent/caregiver declines to participate in an interview, the CPS Case Manager must consult with their supervisor to determine next steps and document the Electronic Record System the CPS Case Manager's attempts to obtain the parent/caregiver's participation.
7. Things to assess for in the parent/caregiver interview:
    a) Determine protective capacity.
    b) Assess safety and risk.
    c) Child's well-being.
    d) Elicit parent's perception of needs and strengths.
    e) Explore effectiveness of services for child/family.
    f) Examine family dynamics such as finances, substance abuse, domestic/family violence.
    g) Explore the parent's feelings, expectations, and perspective about the alleged child victim and siblings.
    h) Knowledge of the allegation concern.
    i) Assess the relationship with the AP and current access to the ACV or OIC.
    j) Knowledge of any other concerns.

Interviewing the AP, if they differ from the Parent/Caregiver

1. Law enforcement and DCS work collaboratively to interview the AP, when applicable.
2. If there is more than one AP, interviews are conducted separately.
3. If the AP declines to participate in an interview, the CPS Case Manager must consult with the supervisor and document in the Electronic Record System the CPS Case Manager's attempts to obtain the AP's participation.
4. If the AP is a minor child, the CPS Case Manager consults with the supervisor and obtains and documents the verbal consent of the parent, custodian or legal guardian before interviewing the minor child. The CPS Case Manager also documents the name and address of the parent, custodial, or legal guardian in the Person's Tab of the Electronic Record System under the "in care of" field.
5. If the AP is a child in DCS custody, the CPS Case Manager contacts the supervisor who consults the applicable RGC to determine if DCS interviews the child. The occurrence of these consultations is documented in the Electronic Record System.
6. Things to assess in AP interview:
    a) View of the child's characteristics, developmental needs, strengths, and condition.
    b) Relationship with the children and others in the family.
    c) Explanation of what happened or is happening that relates to allegation, including how injuries or other consequences occurred; follow-up questions concerning any

inconsistencies in the AP's explanation.

d) Response to the alleged maltreatment and to CPS involvement.

e) What is the current access or level of involvement in parenting the child?

Note: The AP must be interviewed even when the ACV does not make a disclosure.

Interviewing or Observing other Children and/or Interviewing Other Adults Living in the Home

1. The CPS Case Manager interviews/observes all children residing in the household of the ACV and document the interview/observations in the Electronic Record System.
   - Prior to interviewing any child who is not listed or identified as an ACV, the CPS Case Manager obtains permission for the interview and any photographs from the child's parent/caregiver.
2. If the AP resides in a different household from that of the ACV, the child(ren) residing in the AP's home are interviewed as possible victims or witnesses.
   - Prior to interviewing any child who is not listed or identified as an ACV, the CPS Case Manager obtains permission for the interview from the child's parent/caregiver.
3. Other adults living in the home are interviewed in an effort to gather additional information as well as to assist in the assessment of risk and safety.
4. Things to assess with other adults living in the home:
   a) Establish person's relationship to the child.
   b) Assess any knowledge of the incident.
   c) Assess how long and why they are living in the home.
   d) Assess if they are in a caregiver role for the child (ren)
   e) Assess for safety concerns towards the child (ren)
5. Things to assess with other children/siblings living in the home:
   a) Assess for possible victimization.
   b) Potentially corroborate the child's disclosure or provide a witness statement.
   c) Provide a comprehensive family assessment.
   d) The child's characteristics and current condition.
   e) The child's behavior and feelings.
   f) The child's daily routine.
   g) Knowledge of allegation concern.
   h) Assess safety/abuse concerns for this child and, if so, how, when, where, how often, and for how long.

Interviewing Witnesses, Collaterals, and Other Professionals

1. The CPS Case Manager interviews all other persons who may have witnessed the abuse or neglect or have relevant information regarding the circumstances of the ACV and family, including referents, other adults in the home or community, professionals, or staff of other agencies.
2. Things to assess in the witness/collateral interview:
   a) Their role in the life of the ACV and level of involvement.
   b) How do they describe the child?
   c) Knowledge of the child's needs or current concerns with any of the children in the home.
   d) What do they know about the circumstances related to the allegation?
   e) For medical personnel, what is the medical opinion about the parent or caregiver's explanation and any conflicting explanations of injuries?

Allegation Specific Tasks

Physical Abuse

1. *Protocol for CPS Categories and Definitions of Abuse/Neglect* Definition:

   Any non-accidental physical injury or trauma that could cause injury inflicted by a parent, legal custodian, relative or any other person who is responsible for the care, supervision or treatment of the child. Physical abuse also includes, but is not limited to:

   a) A parent or legal custodian/caretaker's failure to protect a child from another person who perpetrated physical abuse on a child;
   b) Injuries, marks and/or bruising that go beyond temporary redness or are in excess of age-appropriate corporal punishment. (e.g., a bruise, broken bone, cut, burn);
   c) Violent behavior by the parent or legal custodian/caretaker that demonstrates a disregard for the presence of a child and could reasonably result in serious injury. Striking (hitting, kicking, punching, slapping, etc.) a child in such a way that would result in internal injury.
   d) Factitious Disorder Imposed on Another (FDIA), formerly known as Munchausen by Proxy Syndrome could be considered physical abuse, medical neglect or psychological abuse.

      Note: Physical abuse should not be confused with developmentally appropriate, discipline-related marks and bruises on the buttocks or legs of children six (6) years of age and older when there are no developmental or physical delays, past history of abuse, or recent (within the past year) screened-out reports.

Note: In its most severe form, physical abuse is likely to cause serious bodily injury or death

2. Case Considerations

   a) When physical abuse concerns are present, identifying and assessing physical abuse and its impact is critical in reducing risk of further harm or injury and potential trauma experienced by children.

   b) Assess for cultural norms related to physical discipline.

   c) Assess for the impact of the physical abuse and/or discipline on the child.

   d) Consider a physical examination by a healthcare provider to determine the extent of injury and relationship to the history provided. The CPS Case Manager may consult with the regional DCS Nurse or a Child Abuse Pediatrician to determine where the exam will take place and by whom.

   e) Consider a consult with the regional DCS Nurse at the beginning of the case, and throughout as needed.

3. Engagement and Interviewing

   a) Recognize that the child may be fearful of talking about the incident, especially if the child received threats to be physically harmed again if disclosing what happened.

   b) The child may feel that the abuse is their fault.

   c) When speaking with the alleged perpetrator, utilize empathetic statements to illicit information such as, “Toilet training is such a difficult time”.

   d) Phrase questions to the alleged perpetrator in a manner that is not accusatory. For example, rather than saying “Do you spank Johnny,” say, “How do you discipline Johnny,” or, “Is the child difficult to parent?”

   e) Observe the child’s body language when asking about the incident, defense mechanisms, dress (is it appropriate for the weather), any visible marks or bruises.

   f) Pay attention to unrelated comments (he/she doesn’t like me, he/she does not care about me)

   g) If the child is alleged to have physical injuries or other observable conditions, the CPS Case Manager must make a direct observation and provide a written description of observed conditions and/or injuries, or the lack thereof, in the Electronic Record System. At a minimum, the documentation describes details of location, color, length, shape, and size of any injury.

      - Photographs must be taken, or drawings are made to supplement the written description. The CPS Case Manager also photographs any objects allegedly used to abuse a child. All photographs must be labeled with the ACV’s name, date and time taken, location where the photograph was taken, and name of person taking the photograph. Photographs of objects are labeled with the name of the object in addition to the information listed above.

- Physical observation of the child's body may include asking the child or parent/caregiver to lift child's clothing to assist in the determination of child safety particularly when the child is nonverbal. Absent a court order giving specific permission, parental permission must be obtained before removing any article of clothing.
- If the ACV's parent/caregiver refuses to allow him or her to be observed, the CPS Case Manager immediately notifies the supervisor, who immediately consults with applicable RGC. These notifications and consultations (without providing the content of consultations) must be documented in the Electronic Record System.

h) Questions to help obtain a timeline:

- When was the child last known to be well or acting normally, without injury?
- What is the child's age and developmental status (on target or delayed)?
- Is there a history of chronic illness or other medical conditions? What are the child's medications, if any?
- When did a medical professional, such as a family doctor, pediatrician, or emergency physician, last see the child?
- When did the caregiver first notice there was a problem? How did it come to his or her attention?
- Where and when did the incident occur?
- Who witnessed the incident? Were there any other objective observers in the vicinity who might have seen or heard something?
- How did the child respond after the incident?
- What did the caregiver do after the incident? Was medical attention needed and did caregiver seek medical care for child?
- How did the symptoms of the injury progress over time?
- Who decided to seek medical attention for the child?

i) Example questions to ask adults during the interview process:

- Tell me what you know about the injury.
- Tell me everything you know about how the injury occurred.
- Please share with me your understanding of how your child was injured.
- Tell me about your child.
- How do you know about the injury?
- Have you observed the injury?
- Did the child tell you about the injury? What did they say?
- Are there current marks or bruises? If so, describe the injury in detail (size, shape, location, and color).

- When did the injury occur?
- Who was present when the injury occurred?
- Where were you when the injury occurred?
- Who has been a caregiver for the child during the past seven days?
- Where is the location of the injury?
- Does the injury require immediate medical treatment?
- Has the child received medical treatment for the injury? By what doctor, clinic, or hospital? Get release of information for medical records.
- Are there any other marks or bruises?
- Were you under the influence of any substances when the abuse occurred?
- Has the child been a victim of abuse prior to this incident?
- When will the alleged perpetrator have access to the child again?

j) Example questions to ask a child during the interview process:

- Can you tell me what happened when you got hurt?
- Do you have marks or bruises now?
- Take pictures of marks and bruises with a witness such as a school nurse or Case Manager when permissible by policy.
- Where were you when the injury occurred?
- Did you tell anyone about what happened?
- How did they react when you told them about what happened?
- Do you feel safe at home?
- What makes you feel safe, good, or happy at home?
- What makes you feel unsafe, sad, or unhappy at home?
- Ask about discipline.
- Who enforces discipline?
- Do the other children in the home get disciplined?
- How are other children in the home disciplined?
- Describe a time when you didn't follow a rule, what happened?
- When you get "spanked, whooped" where on your body does it happen? What is used to "spank, whoop, etc.?"
- When will you next have contact with the alleged perpetrator?

k) Example questions to ask at the Medical Exam:

- What is the child's medical history (including all medications) and the family's

medical history? Is there substance abuse or are there other environmental factors in the home?

- What are the parents' marital status, employment history, and expectations of the child?
- Are the parents' expectations reasonable for what a child of that age should be able to do?
- Was there any delay in treatment for the child?
- Is there any evidence of prior injury, malnutrition, or lack of medical attention? Does the child have multiple injuries in various stages of healing?
- What other specific injuries were identified?
- Have head injuries, eye injuries, fractures, or abdominal injuries been identified? Are blood tests or medical imaging planned?
- Have pictures of the injuries been taken or has medical imaging been ordered?
- Are the injuries life threatening or severe? Does the child need to be admitted to a hospital? If not, what are the safety plans, need for medications, and follow up appointments?
- What is the prognosis for recovery?
- What is the medical plan of care?
- Have there been previous concerns noted?
- Have there been any concerns for the parent/caregiver's compliance with the medical plan of care or follow-up?

4. Assessment of Safety and Risk

   a) Evaluating Safety in Physical Abuse:

   - Are there any injuries present? If so, describe the injury in detail (size, shape, location, and color).
   - When was the injury first seen and who saw it?
   - What explanation does the child give?
   - Does the child require immediate medical treatment?
   - Has medical treatment already been provided? By what doctor, clinic, or hospital?
   - Is there indication that there was use of implements such as belts, boards, irons, cigarettes, or restraints?
   - Are there multiple injuries? Where are the injuries located? What do the injuries look like?
   - Does the victim have an intellectual or developmental disability?
   - Was the alleged perpetrator under the influence of any drugs when the abuse

occurred? Has the child been a victim of abuse prior to this incident?

- Has the alleged perpetrator been convicted of a violent crime or are they currently under investigation for a violent crime?
- Is the alleged victim(s) afraid to go home?
- Why is the child afraid to go home?
- When will the alleged perpetrator have access to the child again?
- Is the child's current caretaker protective?
- Has the non-offending caregiver's protective capacity been diminished based on the perpetrator's coercive control?
- Is there an alternative placement/safety plan in place for alleged victim(s)?
- How does the pattern of abuse put the child danger? (Frequency/severity of abuse, use/presence of weapons, homicidal threats, past criminal record, abuse of pets, child's exposure to the violence)
- What is the perpetrator's state of mind? (Obsessiveness, jealousy, ignoring the negative impacts of the abuse, depression, desperation, threats, use of weapons, thoughts of suicide)
- Are there any co-occurring factors that reduce behavioral control for the non-offending caregiver or perpetrator? (abuse of alcohol or substances, untreated mental health disorders, brain damage)
- Has the non-offending caregiver used force or emotional abuse towards the child or perpetrator?
- What is the child's use of violence?
- Are there situational factors that could increase safety concerns? (Presence of other stressors, increased threat of violence when non-offending caregiver leaves, non-offending caregiver's fear of leaving or inability to leave due to lack of resources)

5. Indicators of Physical Abuse

   a) Child Physical Indicators

   - The presence or history of any sentinel injuries
     - ANY injury to an infant under the age of one year (e.g., bruising, fractures, oral trauma, burns, etc.)
     - ANY bruising in the TEN-FACES areas of a child 3 years and under (Torso [chest, back, abdomen, genitalia, buttocks], Ears, Neck, Frenulum, Angle of the jaw, Cheek [fleshy part], Eyelids, Subconjunctiva (white part of the eyes)
   - Injuries to multiple areas of the body
   - Injuries in various stages of healing
   - Injury reflects the shape/pattern of instrument (cigar/cigarette, hand, etc.)

- Rope marks on wrist, ankle, neck, or torso
- Doughnut shaped burns on buttocks or genitals
- Stocking/glove-like burns on extremities
- Multiple fractures
- Multiple fractures in various stages of healing
- Verbalizes incident(s) of physical abuse or feels abuse was deserved

b) Child Behavioral Indicators

- Appears unhappy or sad, expresses suicidal thoughts
- Is always angry or isolates self from others
- Has difficulty in developing relationships with peers
- Exhibits signs of developmental delays
- Always appears nervous around caretakers/adults or avoids contact
- Afraid of caretaker or is afraid to go home
- Frequent complaints of soreness or pain
- Frequent displays of destructive or cruel behavior
- Frequent runaway incidents

c) Caregiver Behavioral Indicators

- Delay in seeking medical treatment for injury
- Explanation does not match observed injury
- Provided multiple conflicting explanations for injury
- Attempts to conceal injury or avoids discussing injury
- Attempts to protect alleged abusive caretaker or minimizes child's injury
- Uses harsh, inappropriate disciplinary practices
- Poor impulse control
- Medication, alcohol, or illegal drug misuse
- Verbal or physical domestic violence
- Mental or emotional health issues

6. Factitious Disorder Imposed on Another (FDIA) /Medical Child Abuse/ Munchausen Syndrome by Proxy

a) Child Warning Signs:

- History of repeated injuries, illnesses, or hospitalizations.
- Symptoms that don't quite fit any disease.

- Symptoms that don't match test results.
- Symptoms that seem to improve under medical care, or while the child is with another caregiver, but get worse at home.

b) Caregiver warning signs:

- Attention-seeking behavior.
- Striving to appear self-sacrificing and devoted.
- Becoming overly involved with doctors and medical staff.
- Refusing to leave the child's side.
- Exaggerating the child's symptoms or speaking for the child.
- Appearing to enjoy the hospital environment and the attention the child receives.

c) Example questions to ask the caregiver during the interview process:

- Does the child have a history of many hospitalizations? (Note if the child often has been hospitalized with a strange set of symptoms).
- Have you had any other children that have had any unusual illnesses?
- Has there been a death of other children in the family?

d) Example questions to ask a medical provider during the interview process:

- Has the child been hospitalized?
- Do they have frequent doctor visits and/or multiple doctors?
- Has the child received multiple medical procedures?
- Is there a worsening of the child's symptoms generally reported by the caregiver and is not witnessed by anyone else?
- Do the child's reported condition and symptoms agree with the results of tests?
- Has the child's condition improved in the hospital, but symptoms recur when the child returns home?

7. Conducting Home Visits and Other Site Visits

a) Observe the home environment of the ACV, including a second home and/or site of the alleged incident, including all areas related to the allegations in the report and in compliance with best practice.

b) Observe, document, and take pictures of the entire home/location of the incident, also any items that could have caused the injury

c) Take measurements of areas in the home/scene related to the allegation (ex. Child has a black eye alleged to have been caused by being accidentally hit in the eye by a doorknob. Measure height of doorknob and height of child).

d) Assess family history (including medical history, mental health history, health status of the child and medications).

e) Assess for any professional's involved with the family? (in home providers, TEIS, GAL, counselors, etc.).

8. Planning with the Family
   a) Safety Plan action steps for the alleged perpetrator can include:
      - Removing physical discipline as a practice in the home.
      - Leaving the house during the course of the investigation.
      - Utilizing cool off periods or "time-outs" when escalated.
      - Attending recommended service interventions.
      - Identifying which friends and family members can also help hold perpetrator accountable to not physically discipline the child.
9. Documentation
   a) Documentation in physical abuse cases should utilize accurate use and entry of information assessed by completing a holistic approach throughout the case to address the safety of children.
   b) Document the details of location, color, length, shape, and size of any injury.
   c) Photograph the physical injuries and any objects allegedly used to abuse a child.
   d) Physical observation of the child's body may include asking the child or parent/caregiver to lift child's clothing to assist in the determination of child safety particularly when the child is nonverbal. Absent a court order giving specific permission, parental permission must be obtained before removing any article of clothing.
   e) Corroborate details/statements by:
      - Ensuring any disclosure from the child and/or the perpetrator statements are entered accurately.
      - Include witness testimony.
      - Document all medical records, specifically the records pertaining to the allegation incident.
10. Classification and Case Closure
    a) Factors to consider when classifying a physical abuse allegation:
       - Does the evidence demonstrate the injury could have occurred the way the AP said it did?
       - Was the child developmentally mature enough to cause the injury?
    b) Assess:
       - Birth records for any indications of abuse.
       - Past/present medical and/or psychological record.
       - Records regarding the allegation incident.

- Photos and location of the injury on the child for indications of abuse.
- Photographs of the injury.
- Photographs of the scene of the incident.
- Law enforcement records.
- Photographs of objects used to cause the abuse.
- Physical evidence.
- Circumstantial evidence linking the alleged perpetrator to the abusive act.
- Patterns of repeated behavior that may be indicative of child abuse.

c) Review:

- The child's statement for corroborative details.
- The AP's statement for any admissions or corroborative details that correlate with the child's statement.
- Witness statements regarding the abusive act.
- Results of the assessment tools used in the case.

d) Use corroborating evidence to uphold physical abuse substantiations:

- Photos of injury (or lack of visible injury).
- Medical records.
- Well documented ACV statement.
- Photo of location of the abuse.
- Photo of object used to cause the abuse.
- Law enforcement reports.
- Witness statements.

Drug Exposed Child

1. *Protocol for CPS Categories and Definitions of Abuse/Neglect* Definition:

   This allegation pertains to a person under the age of eighteen (18) who:

   a) Has been exposed to or experiencing withdrawal from use, sale, or manufacture of a drug or chemical substance (including, but not limited to alcohol such as a diagnosis of Fetal Alcohol Syndrome, cannabis, hallucinogens, stimulants, sedatives, narcotics, methamphetamines, heroin, inhalants) that could adversely affect the child's physical, mental, or emotional functioning as a result of the actions or behaviors of the parent/caregiver; or

   b) Has a parent/caregiver that uses drugs or chemical substances that impacts their ability

to adequately care for the child; or

c) Has a parent/caregiver that has current addiction issues that could adversely affect the child's physical, mental, or emotional functioning.

d) Drug Exposed Child (Severe)

- Severe forms of this allegation include but is not limited to:
  - The manufacturing of methamphetamine where children are present, or in close proximity;
  - Infants born with a diagnosis of Fetal Alcohol Spectrum Disorder (FASD);
  - Infants born with a diagnosis of Neo-Natal Abstinence Syndrome (NAS) where the diagnosis is not based on the mother's prescribed and appropriately followed Medication-Assisted Treatment;
  - Knowingly or with gross negligence allowing a child under eight (8) years of age to ingest an illegal substance or a controlled substance that results in the child testing positive on a drug screen, except as legally prescribed to the child; and/or
  - Knowingly allowing a child to be within a structure where a Schedule I controlled substance under TCA 39-17-406, cocaine, methamphetamine and/or fentanyl are present and accessible by the child.
- If, during the course of assessment in a non-severe case, additional information is gathered that meets the criteria for severe abuse, CPIT must be convened; the track should be flipped to Investigations if necessary.

e) A referral meets the criteria for the investigation track when one or more of the following applies:

- The alleged child victim (ACV) is age 0 thru 3 months.
- The ACV has a positive drug screen for an illegal or unprescribed drug.
- The alleged perpetrator (AP) directly administers, provides, or uses legal or illegal drugs resulting in harm to the ACV.
- The parent/caregiver's misuse of prescription medication has caused physical, mental, or emotional harm; or
- The referral involves the manufacturing of methamphetamine.
- Two additions to the severe abuse statute regarding Drug Exposure:
  - Allowing a child to be within a structure.
    - Knowingly allowing a child (any child under the age of 18) to be within a structure where the following drugs are present and accessible to the child:
      - Any Schedule 1 substance listed in Tennessee Code Annotated 39-17-406.
      - Cocaine
      - Methamphetamine, or

- Fentanyl.

- Allowing a child under the age of 8 to ingest
  - Knowingly or with gross negligence allowing a child under the age of 8 to ingest an illegal or controlled substance that results in the child testing positive on any drug screen, except as legally prescribed to the child.

f) What is a structure?
   - ♦ Includes but is not limited to the following:
   - ♦ Homes
   - ♦ Sheds
   - ♦ Cars
   - ♦ Barns

g) Drugs included in 39-17-406
   - ♦ Opiates and Opiate Derivatives (Heroin)
   - ♦ Hallucinogens (LSD, Peyote, etc.)
   - ♦ GHB
   - ♦ MDMA
   - ♦ Some Compounds of Amphetamine
   - ♦ Cocaine
   - ♦ Methamphetamine
   - ♦ Fentanyl

h) If referral is received from a hospital, the hospital is contacted within 24 hours of the intake per the hospital protocol (embed link). The following information should be obtained from the hospital. Hospital protocol also states that a minimum of weekly contact is to be made with the hospital for the duration of time the child is hospitalized.
   - ♦ Verification of the information reported.
   - ♦ Discharge Date?
   - ♦ Are the parents present?
   - ♦ Any concerns with the parents or their care of the child?
   - ♦ Cord stat, meconium, or urine drug screen results?
   - ♦ Any diagnosis?
   - ♦ Verification of the family's address as reported.
   - ♦ Do the parents have any other children?

2. Case Considerations

Tennessee DCS Substance Use Guiding Principles

a) The Tennessee Department of Children's Services (DCS) recognizes that substance abuse by parents is a major factor affecting children's physical health, mental health, and safety. DCS believes that once substance abuse is identified as a barrier to parenting, the most effective way to enhance children's safety is to support the child, youth, parents with comprehensive services. DCS's preference is to support children safely at home by providing preventive and substance abuse treatment services that promote safety, recovery, and well-being. If this is not possible and removal is necessary, the parent should receive timely and appropriate substance abuse services to expedite reunification.

b) All child welfare staff should have a clear and in-depth understanding of substance abuse, treatment, and the recovery process, and how it, directly and indirectly, impacts children, youth, and families.

c) Substance abuse can pose a serious risk to the health of an individual, undermines family stability, and negatively impacts child safety, well-being, and emotional development.

d) Current and past use of substances is not the sole determinant of whether or not a person will be a good parent.

e) Various types of substance abuse treatment can work in helping the client progress toward recovery.

f) Child welfare staff should receive appropriate training, consultation, and resources to effectively assist parents and/or youth achieve recovery.

g) All children, youth, and families deserve a strength-based and holistic approach to assessment that promotes a comprehensive understanding of their issues and service needs.

h) Clients identified with substance abuse issues and their families should receive a comprehensive assessment to determine safety, strengths and services needed.

i) Assessments of clients' needs, and progress should be ongoing to address any changes.

j) Substance abuse does not solely affect the person abusing drugs, it all affects the entire family unit. All children, youth, and families affected by substance abuse deserve a fair and timely opportunity to receive needed services that will assist them in attaining safe, nurturing, and permanent homes.

k) Interventions should include a range and continuum of services including, but not limited to prevention, comprehensive treatment, and aftercare that are responsive to the client's and his/her family's needs and promote parental responsibility, child safety and permanency.

l) All families deserve access to high quality and well managed services regardless of ability to pay.

m) Clients are best served by community-based services, which helps to remove the

barriers to accessibility and maintain family connections.

n) Every client in the child welfare system must be involved in developing his or her service plan.

o) The client, child welfare staff, and treatment providers are all responsible for fulfilling mutually developed services and must work as partners to ensure positive outcomes.

p) Think through the short- and long-term effects of substance usage and how those can impact an individual in a caregiving role. For example: Methamphetamine usage will suppress one's appetite, so that individual may not be thinking about preparing meals or feeding their children. You will want to ask questions about meals and food.

q) All individuals affected by substance abuse as well as child welfare staff have a responsibility to appropriately respond to substance abuse issues to foster and maintain child safety, family stability, and recovery.

r) Parents need to understand how their substance abuse is affecting their child's safety and well-being and be willing to make progress to ensure safety, well-being and permanency.

s) Families affected by substance abuse must be given adequate opportunity to address their challenges and obtain support to strengthen their ability to achieve recovery, stability, and healthy relationships.

t) Communication and sharing of information about families impacted by substance abuse should be done in a respectful manner and in compliance with the family's rights to confidentiality.

u) The child welfare system should work with other systems and providers to remove barriers and create systems of care that effectively respond to the complex needs of families and promote healthy and safe families.

3. Engagement and Interviewing

a) Interviewing the Non-offending Caregiver

- Explore extent and severity of caregiver's/alleged perpetrator's substance use.
- Avoid any blaming questions, don't ask "why" questions. Use, "How did we get here?" Can the issue be connected to trauma and/or mental health?
- Explore any knowledge of prior substance abuse challenges of the other caregiver, any behavioral indicators, treatments attempted or completed, triggers of use and motivations to achieve sobriety.

b) Interviewing the Child

- Use age and developmentally appropriate, open-ended questions.
- Does anyone in your house take medicine, if so what for?
- Does anyone in your house drink alcohol? Can you describe what they drink and how often they drink?

- How does that person act when they take medicine or drink alcohol?
- Do you know what drugs are? Tell me about what you know.
- If no, have you ever heard that word used before?
- Have you been to the doctor and gotten a shot before? Does anyone else you know get shots?
- Is there anyone in the home that is hard to wake up? When do your parents sleep? Where do they sleep? Where do you sleep? What do you do when your parents are sleeping? How do you wake them up when you need them?
- Does anyone in your house smoke? Can you describe what they smoke? How do they act after they smoke? Are there any different smells?

c) Interviewing the alleged perpetrator

- Use the DEC intake form as a tool to ensure a global assessment is completed.
- Assess whether the AP may be currently under the influence or being impacted by substance abuse/withdrawal. Focus on understanding the perpetrator's state of mind, history of trauma, and mental health issues, as this may be crucial in the safety planning process.
- Do you continue to use despite negative consequences?
- Do you ever use alone?
- Do you feel it is impossible for you to live without drugs?
- How do you pay for your drugs?
- Do you put the purchase of drugs ahead of your financial responsibilities?
- How often do you use drugs?
- Do you think you might have a drug problem?
- Does the thought of running out of drugs terrify you?
- Does using interfere with your sleeping or eating?
- Has your job or school performance ever suffered due to your drug use?
- Do you have a history of drug use?
- What is your drug of choice?
- Have you ever gotten help for your drug problem, what worked what didn't work?
- Have you ever manipulated or lied to a doctor to obtain prescription drugs?
- Have you ever overdosed on any drugs?
- What happens when you don't get your "fix"?
- Have you ever used drugs because of emotional pain or stress?
- Is your drug use making life at home unhappy?

- Do you currently have any prescribed medication? Complete a pill count if there are medications.
- What medications are you prescribed and what is the diagnosis they are prescribed for?
- Who do you see when you are sick? Do you see any specialists or other types of caregivers?
- What pharmacy do you use?
- What happens if you run out of your prescribed medication?

  Note: Always be mindful of stigma in how we speak when interviewing and speaking with families regarding substance use. Watch for stigma in our language about substance use. Here are some ways we can change how we speak:

  - Negative instead of Clean
  - Positive instead of Dirty
  - Return to Use instead of Relapse
  - Substance Use Disorder instead of Addiction
  - Person with Substance Use Disorder instead of Addict
  - Drug dependent infants instead of drug addicted infants

d) Interviewing of Witnesses

- How does the drug use affect the caregiver's ability to parent?
- Do the children have access, or could they get access?
- How is the parent getting the drugs?
- Have they admitted to the use of a drug or chemical substance?
- What type of drugs is the parent/caregiver using?
- How do you know that there is drug use?
- Have you personally witnessed the drug use? When?
- If you have not witnessed the drug use, do you know anybody who has? Name? Address? Phone?
- Is the parent/caregiver abusing any medication that is prescribed to them?
- Do you know what are they prescribed?
- Do you know the parent/caregiver's diagnosis or why are they prescribed this medication?
- How are the parents/ caregivers getting their drugs?
- Do you know if they trading or pawning items to get drugs?
- Do the parents/caregivers use drugs in the presence of the children?

- How do the parents act when they are under the influence of the drug?
- Are the parents/caregivers caring for the children while they are under the influence of drugs or substances?
- How is the caregiver's drug usage affecting the child? Because of the use, is the child going without food, utilities, shelter, school, clothing, and/or proper supervision?
- Does the parent/caregiver drive under the influence of substances while the children are in the car with them? If so, how often does this happen? When did this last happen? How do you know?
- Are the parents/caretaker's providing drugs to the children? If so, what was given to the child? How often does this happen? When was the last time this occurred? How did the child behave while under the influence of these substances/drugs?
- Do you know where they store their drugs?
- Are the parents/caretakers' leaving drugs or drug paraphernalia within reach of the children? If yes, what types of items are left out within reach of the children? Has the child ever been seen handling these items? If so, when? Who saw them?
- Do the parent/caretakers take their children with them when they are purchasing, selling, or trading drugs or substances? Do any of these transactions take place inside the home in which the children reside?
- Is there heavy traffic in and out of the home in which they live?
- Has the parent/caretaker ever been arrested on drug-related charges? If so, do you know the charges and date of the offense?

4. Drug Exposed Newborns
   a) Example questions to ask parents during the interview process:
      - Are you prescribed any medications?
      - What are the medications prescribed for?
      - Who prescribed you the medication? (Get release of information signed to obtain medical records).
      - What pharmacy do you use when filling your prescriptions? (Get separate release of information for pharmacy records).
      - Do you have a history of drug use?
      - What is your drug of choice?
      - How often are you using?
      - When is the last time you used?
      - Who did you see for your prenatal care?
      - Did you test positive of any substance during prenatal care? (Get separate release of information for prenatal care).

- Was your child born full term? If not how many weeks gestation? (Get separate release of information for Labor and Delivery records)
- Does your baby have any medical or physical complications due to drug exposure that you are aware of?
- How have you prepared for the child? (car seat, diapers, formula, family support, etc.)
- Tell me about your support system?
- What is your plan for when you may be released from the hospital? (living arrangements, transportation, medical care)
- Do you have any other children? If yes, did you use during pregnancy with your other children?
- Who has custody of your other children?

b) Example questions to ask a medical professional to elicit information during an interview:

- Did the mother test positive at admission for delivery of this child?
- What drug did the mother test positive for? Ask for a copy of the drug screen.
- Was she given any medication at the hospital before she was tested?
- Was she on any prescription medications that would have caused her to test positive?
- Has the prescription been verified? By whom? How?
- Did she take these medications as prescribed?
- Did the baby test positive for drugs at birth? If so, what drug?
- Has a meconium/umbilical cord been collected? What are the results, if known?
- What is the mother's explanation?
- Has mother made an admission of use? What did she say?
- What drugs/substances is the mother using?
- How often is she using?
- When did she last use?
- Did the mother have prenatal care?
- Did mother test positive during prenatal care?
- Was the child born full term? If not how many weeks gestation?
- Are you aware of any medical or physical complications for the baby due to drug exposure?
- Is the newborn showing any signs of withdrawal?

- What are the newborn's symptoms?
- What treatment is being given due to these symptoms?
- Has the mother prepared for the child? (car seat, diapers, formula, family support, etc.)
- Does the mother have a support system? If so, who?
- Is mother bonding well with this child?
- When will the mother and baby be released from the hospital?
- If the child now has special needs because of the drug exposure, is the mother aware and willing to get prepared for caring for the child medically?

5. Assessment of Safety and Risk

a) If a referral is received while ACV is still at the hospital, then the response is met at the hospital within the response time. If the ACV is being discharged home prior to the priority response due date/time, response is met prior to ACV's discharge. If ACV is not an infant and is old enough to be interviewed, the ACV should be interviewed separately and privately whenever possible. Case Manager should be using Motivational Interviewing practices whenever possible (embed link).

b) A home visit is completed prior to the infant's discharge or at minimum the day of the infant's discharge to ensure safety of the home and safe sleep.

c) Safe Sleep is reviewed with the family to ensure understanding.

d) Safe sleep assessment (embed link) is completed with the parent/caregiver.

e) The safe sleep space is observed by the case manager. If there is any question regarding whether a safe sleep space is appropriate, please contact the regional DCS Nurse.

f) The safe sleep assessment is uploaded in the Electronic Record System. If Safe Sleep is unavailable or is not adequate, a pack and play will be provided by DCS to the family, prior to the case manager leaving the home. (Another DCS Case Manager will be engaged to bring a Pack and Play from the office to the home.)

g) If ACV is not a newborn at the hospital, or if the ACV is already discharged home when the referral is received, then response is met within the assigned response time. However, it is best practice to complete the home visit the day of assignment to verify safe sleep for newborns and children under the age of 12 months.

h) Requesting Background Checks- When addressing allegations of Drug Exposed Child for all CPS cases, requesting LE records and completing internet background checks is an important step to verify/confirm if there is a history of substance use in which LE has been involved. The following are different checks that can be completed.

- Local Background Checks (CS-0751, Background Clearance Check - Local Criminal History) through local law enforcement.
- TNCRTINFO.COM

- Tennessee Drug Offender Registry
- National Sex Offender Registry
- Tennessee Felony Registry
- Vulnerable Persons Registry
- Contacting Probation and Parole (obtained signed release of information)

i) Evaluating for Impairment - When addressing allegations of Drug Exposed Child for all CPS cases, evaluating for impairment should be done at every interaction with the family. Evidence of impairment include but are not limited to the following. When evaluating for impairment, keep in mind that some behaviors may be a result of other disabilities or delays.

- Slurred speech
- Glassy eyes
- Dilated Pupils
- Restricted Pupils
- Difficulty staying awake
- Slow movements
- Inability to stay on topic during conversation
- Talking too fast
- Talking too slow
- Making irrational statements
- “Meth Sores”
- Needle “track” marks
- “Meth mouth” includes rotting teeth, missing teeth, dry mouth
- Mouth and/or finger blisters or burns
- Paranoia
- Hallucinations

j) Recognizing Paraphernalia - When addressing allegations of Drug Exposed Child for all CPS cases, recognizing drug paraphernalia is important in assessing for safety in the home. Examples of drug paraphernalia include but are not limited to the following:

- Cut straws
- Burned Spoon
- Scales
- Baggies

- Pipes/Bowls/Bongs
- Needles/Syringes
- Rolling Papers
- Roach Clips
- Plate or mirror with residue

k) Drug Testing is a TOOL to assess safety and risk.

- What type of screening is needed?
- How often is screening needed? Consider CSR for more frequent screening.
- Observation of urine drug screens should only be completed by staff of the same identified gender.

l) Collaterals when addressing concerns with older children.

- Teachers
- School Resource Officers
- Guidance Counselors
- Neighbors
- Community Engagement
- Coalitions
- Food Banks/Pantries
- Service providers
- Hospitals
- Medication Assisted Treatment Clinics
- Treatment Centers

6. Planning with the Family

a) Non-Custodial Family Permanency Plan (refer to DCS Policy *14.12, Family Permanency Planning for Child Protective Services Non-Custodial Cases*).

- A NCPP is appropriate for service planning and next steps.
- A NCPP should be completed when the family is being asked to complete and comply with services or next steps.
- A NCPP should always be completed when a case meets the criteria for CARA.
- A NCPP is required when a case is transferring to Family Support Services (refer to DCS Policy *14.18, Family Support Services Program*).
- Involve/Engage the family in the development of the plan. This is referring to the family's entire support system.

- When developing NCPPs for Drug Exposed Child concerns/allegations, a return to use prevention plan needs to be included in the plan.
- Random drug screens and pills counts should be part of the plan. These screens can include hair, nail, urine, and saliva testing. (Reminder- Never touch a client's medication yourself. Have the client count their medicine while you observe.)
- Services should be requested and implemented in a timely manner within the first 30 days of the case.
- CSR extensions should always be entered timely to prevent a lapse or delay in services.

7. CPS Investigations Involving Methamphetamine Labs

a) Request for Law Enforcement assistance

- When a referral is initially received by DCS alleging a report of a clandestine lab (Definition of Clandestine: A methamphetamine lab is sometimes referred to as a clandestine laboratory by law enforcement officials. The more common street name is, "mom and pop" labs. The primary purpose of these labs is to manufacture illegal controlled substances such as methamphetamine. These labs pose a variety of hazards to the environment and most importantly to people. The Case Manager must contact local law enforcement immediately to request assistance.
- The Case Manager must coordinate the DCS investigation with law enforcement and respond as quickly as possible to the designated location and follow response Priority 1 guidelines as outlined in DCS Policy *14.2, Screening, Priority Response and Assignment of Child Protective Services Cases*.

b) When it is Confirmed that a clandestine lab has been found:

- When a Case Manager responds to the lab site, remain in a safe location outside of any established perimeter until otherwise advised by law enforcement that it is safe to proceed.
- DCS Case Managers will not enter a residence where the manufacturing of methamphetamine has been confirmed.
- When clearance is given by law enforcement, the Case Manager assesses and interviews the children.
- The Case Manager must immediately contact the CPS Supervisor and legal staff to seek a legal remedy to protect the child.
- When assessing the home environment, ask the investigating officer to look for excessive quantities or a combination of the following items commonly found in a drug laboratory which are often located in areas of the house or garage accessible to children:
  - Funnels, flasks, plastic tubing, large plastic containers, beakers
  - Drano, iodine crystals, Red Devil lye, acids, anhydrous ammonia, cold medications such as Actifed, Sudafed, rock salt.

- A large variety of chemicals, which may be stored in food preparation areas or the refrigerator in unlabeled or inappropriately labeled food or drink containers such as juice container, soft drink bottles or ordinary pitchers.

♦ Request that the investigating officer complete the following tasks and make them part and parcel to the criminal investigation:

- Take measurements of the dangers in relation to the child's height, i.e. if the drugs/lab apparatus/ingredients are on a table, how high is the table in relation to the child;
- Describe the child's access to the drugs and/or drug paraphernalia in the home;
- Photograph every room in the house paying particular attention to the location of the proximity to hazards in relation to the child's play area, sleeping area, food prep and eating area;
- Document the location of any weapons or pornography that might be in the home;
- Document food quantity and quality;
- Document the ventilation in the home or lack thereof;
- Document the potential for fire or explosion;
- Detail all hazards found at the scene;
- Photograph the children to document any injuries observed on the children and the physical appearance of the child. (If the law enforcement officer does not wish to photograph the child, this must be done so by the Case Manager).
- Do not make the child's photographs part of the evidence in the criminal investigation. Do not have more than one original copy of all photographs. There will be only one set of original photographs taken by law enforcement.

♦ There may have been other children in the home who were not present at the time of methamphetamine lab seizure. These children need to be located and undergo a medical examination much like the children found at the lab site.[Refer to Section (e), Protocols for safety of children.] The Case Manager needs to discuss these children with the CPS Supervisor and Legal staff to ensure the child's safety.

c) When a Case Manager unexpectedly enters a site where drugs are currently being manufactured:

♦ The Case Manager must leave the area immediately or as soon as possible if he or she suspects an operational or non-operational methamphetamine laboratory is housed inside or outside of a residence.

♦ THE CASE MANAGER MUST NEVER use sense of smell or touch to attempt to identify chemicals or unknown substances.

♦ The Case Manager must not walk through any area where chemicals may have been spilled. If the Case Manager develops reasonable suspicion of a methamphetamine

lab while in the course of a home visit, efforts must be made to conclude the visit quickly, without causing concern to the individuals of the household that suspicion has developed. This is extremely important due to the extremely aggressive behavior, rapid mood swings and paranoia that use of methamphetamine may elicit.

- ♦ While in the home they do not:
  - o Touch, move, lift, carry, push or slide anything
  - o Shut off/turn on anything such as electrical machinery
  - o Turn lights or electrical appliances on or off
  - o Open refrigerator doors
- ♦ Exit the home immediately and notify law enforcement of the situation and coordinate the investigation. Local law enforcement agencies should have established a specific protocol for use when reports of methamphetamine laboratories are received.
- ♦ The Case Manager must immediately contact the CPS Supervisor and Legal Staff to seek a legal remedy to protect the child.
- ♦ Follow the procedures included in Section B.

d) When the Case Manager has been exposed to a methamphetamine lab:

- ♦ If the Case Manager is exposed to the area or building where methamphetamine is being or has been manufactured, decontamination procedures must be followed as outlined below:
  - o Contaminated clothes must not be worn into the home, vehicle, or office if at all possible;
  - o The Case Manager must thoroughly shower as soon as possible using soap and water.
  - o Clothes must be washed in a mixture of water and bleach, and an empty cycle must run through the washing machine with water and bleach mixture.
  - o Soles of the shoes must be cleaned with soap and water.
  - o If the Case Manager experiences physical symptoms and needs medical attention, he or she must seek medical attention immediately and begin Case Manager's Compensation procedures by contacting Division of Human Resources. (Details of symptoms associated with methamphetamine poisoning are located in the Resource Data on Methamphetamine).

e) Protocols for Safety of Children

- ♦ If a child has been removed from a home where a known or suspected methamphetamine laboratory has been located and there is suspicion that the child was exposed to chemicals, the following procedures must be followed:
  - o The Case Manager must not remove any items from the home. Any items

(clothes, toys, etc.) from the house may be contaminated and pose further risk. The child must be decontaminated (defined as, at a minimum, washing the children and changing their clothes) before being transported to a medical facility for a medical assessment.

- A field medical assessment is performed to determine if the child is in need of immediate emergency care. The assessment can be performed by a medically trained person (i.e., an EMT, paramedic, nurse, etc.).
- If the child is to be transported before decontamination, ask for police or EMS assistance. The child can be placed in a Tyvex suit or wrapped in a thermal blanket (space blanket) and transported to the appropriate medical facility for decontamination.
- Once at the medical facility, decontamination needs to be completed as consistent with unknown chemical exposure.
- After decontamination, a medical evaluation is completed on the child. The following is checked:
  - Complete blood count;
  - Renal and liver functions;
  - urine drug screen with zero tolerance; and
  - A lead level.
  - For more information on medical protocols for a child/children who live at or visit drug-production sites refer to website: *http://digitalcommons.unl.edu/cgi/viewcontent.cgi?article=1011andcontext=cflpubs*
- A complete and thorough head-to-toe examination must be performed. Specific screening may also be warranted based on the case circumstances, such as a chest x-ray, skeletal survey or pregnancy/sexually transmitted disease screening.
- The child's first urine after discovery in a methamphetamine lab is collected and maintained by hospital personnel until collected by law enforcement (using standard chain of custody techniques as you would other evidence).

f) Written Local Procedures

Each DCS office must meet with its local law enforcement office and District Attorney's office to establish written procedures for entering homes where children are present and there is a belief that an operational or nonoperational methamphetamine laboratory exists.

8. See Safety Notices

a) *Understanding the Difference between Subutex and Suboxone*

b) *Utilizing Medical Records as Part of Substance Abuse Assessment*

c) *Assessing a Newborn's Drug Exposure*

d) *Understanding Fentanyl and Avoiding Accidental Exposure*

Environmental Neglect

1. *Protocol for CPS Categories and Definitions of Abuse/Neglect* Definition:

   A living situation either inside or outside the residence that is dangerous or unhealthy. The situation described can cause harm or significant risk of harm to the child(ren) in the home. The child's age and developmental status is considered when evaluating the impact of the environmental condition of the child. Poverty is not evidence of neglect, as per federal guidelines. The following are some examples of environmental situations as they relate to the child's age and developmental status:

   a) Leaking gas from stove or heating unit;

   b) Substances or objects accessible to the child that may endanger health/safety;

   c) Open/broken/missing windows;

   d) Structural hazards such as caving roof, holes in floor or walls;

   e) Exposed electrical wires;

   f) Children that lack clothing so that they are dangerously exposed to the elements, i.e., not having shoes or warm clothing for winter, etc.;

   g) Excessive garbage or rotted or spoiled food, which threatens health;

   h) Evidence of human or animal waste in the living quarters;

   i) Insect or rodent infestation; and

   j) Lack of or inability to obtain appropriate hygiene which threatens the health and well-being of a child, including the refusal to allow the child to bathe.

      Note: In its most severe form, serious illness or significant injury has occurred due to living conditions and these conditions still exist (e.g., lead poisoning, rat bites).

2. Case Considerations

   a) The child's age and developmental status must be considered when evaluating the impact of the environmental condition of the child.

   b) A child with an underlying medical condition that is negatively affected by the living condition must also be considered.

3. Engagement and Interviewing

   a) When speaking with the alleged perpetrator or caregiver, one will want to ask them:

      - What are their thoughts about the condition of the living environment?
      - Are they aware of the possible injuries or illnesses that could occur for a specific person residing in that environment?
      - What steps have they historically and recently taken to address any identified

concerns about their living condition? This includes reaching out to landlords to address problems with the home condition.

- What current supports do they have to address the environmental concerns?
- What supports or services do they feel that they need?
- Do you have utilities turned on and are they functioning properly?
- Is there an alternate plan for lack of utilities?
- Do the children bathe at another location?
- Are there any safety hazards such as exposed wiring, leaking gas, structural damage, or guns/weapons accessible to the children?
- Are there any health hazards such as human or animal feces, insect or rodent infestation, excessive garbage, or rotten/spoiled food in the home?
- Are there serious medical conditions that are adversely affected by the current living conditions?
- Does the family have relatives who help them?
- Does the family have access to community resources?
- Medical repercussions?

b) When speaking with the alleged child victim, one will want to ask them:

- Tell me about your house.
- Do you have bugs in your house? What kind? Where?
- Do you have animals in your house? Who takes care of the animals and ensures they go outside to the bathroom during the day and before bedtime?
- Where do you sleep?
- Do you have running water and electricity at home? Where do you take a bath? When was your last bath?

c) Speak with witnesses, collaterals, other professionals, or agencies and ask them:

- What their role is to the child/family
- What concerns do they have for the child/family?
- How are the children being impacted by the environmental neglect?
- What do they know about the child or children's physical appearance and effect on a daily basis?
- Describe the child to include their emotions and behaviors.
- If speaking to an environmental professional, what is their professional input about the situation? (If speaking to an exterminator, etc)
- What are their thoughts on the parent/caregiver's level of functioning and their

ability to understand the situation?

4. Assessment of Safety and Risk

   a) If there are reported and/or observed concerns for the safety and health of a child due to the conditions of the home, all living spaces should be closely examined, includes any basement, attic, and/or crawl space that the child has access to.

   b) When assessing the living environment, look for the following that could be considered dangerous or unhealthy for the specific children residing in that environment:

      - Environmental conditions (mold, fungus, smoke, pet hair and dander, dust, room temperature, bugs, etc.) that may trigger respiratory illnesses.
      - Rodent (rats, mice, etc.) infestations can contribute to the spread of diseases by handling rodents, through contact with rodent feces, urine, or saliva, or through rodent bites. Diseases carried by rodents can also be spread indirectly through ticks, mites or fleas have fed on an infected rodent.
      - Insect (bed bugs, roaches, lice, scabies, fleas, spiders, infestations can contribute to the risk of being bit which may cause an allergic reaction.
      - Be aware of suffocation hazards such as a small child playing with plastic bags that are accessible to them.
      - Poor hygiene could affect the health and well-being of a child. This could lead to the spread of illnesses and diseases. It can also cause a negative impact on the child's mental health.
      - Wearing improper clothing or shoes can place the child in a situation where they are exposed to extreme heat or cold. Exposing children to extreme cold or heat can cause illness. Improper clothing may also lead to psychological issues as the child may become a target of ridicule and/or bullying from peers.
      - Excessive garbage could lead to exposure to feces-contaminated waste, chemicals, blood-borne pathogens, and sharp objects. The presence and consumption of spoiled or rotten food can result in illness.
      - Human and Animal Waste (urine, feces, vomit, used diapers, used feminine products, etc.) that are not properly disposed of or cleaned up after can contribute to the spread of disease.
      - Exposure and access to toxic substances (Rat poison and mice baits, cleaning chemicals, medications).
      - There is the potential for fire hazards where there is excessive clutter/hoarding, exposed electrical wiring, improper usage of space heaters, fireplaces, kitchen appliances.
      - Structural Hazards (exposed electrical wiring, holes in ceilings, walls, or decaying floorboards, etc.) could lead to physical injuries. Be aware of furniture hazards that could cause injury to the child.
      - Be aware if homelessness impacts if basic needs are being met such as hygiene,

protection from the elements and weather, etc.

c) Consult with regional DCS Nurses, Psychologists, Educational Specialist, etc. as needed

d) If one encounters an ACV who needs medical treatment due the environmental neglect, the Case Manager will ask parent/caregiver to identify the ACV's physician, to make arrangements for the ACV to receive medical treatment and ensure that the ACV has transportation to the appointment.

e) Obtain medical records for ACV's history if it is believed the environmental neglect has been causing long term issues

f) The Case Manager obtains a forensic medical evaluation when the case involves obvious severe injury/conditions, or when a medical opinion is needed.

5. Planning with the Family

a) Do the environmental concerns cause immediate safety concerns?

b) How can those safety concerns be addressed?

c) What action steps must occur to ensure safety?

d) How timely can they be addressed?

e) Utilize United Way Tennessee 211's website and Aunt Bertha app in locating resources and services in the area that are specific to the family's needs.

f) Reach out to your resource linkage coordinator to determine what services and assistance is available to the family based on their needs.

g) Complete a CSR for usage of funds to help address and assist the family's needs.

h) Examples of possible services (not all inclusive):

- Homemaker services to assist the family in organization and cleanliness of their home.
- Pest Control
- Utility Assistance
- Dumpster Service to remove excess waste causing safety issues
- Electrical issues related to safety issues
- Carpenters for any structural hazards
- Necessary furnishings and clothing
- Local Health Department for lice treatments, toothbrushes, toothpaste, hairbrushes, underwear, and diapers.
- Assist in finding alternative housing options

6. Documentation

a) The overall environment must be described in the case recordings. Physical status of the home, including cleanliness, structure, smell, hazards, or dangerous living

conditions. Documentation must include evidence-based observations.

b) The documentation should clearly identify if the living situation inside or outside of the home can be considered dangerous or unhealthy and how the situation can cause harm or significant risk of harm to the child(ren) in the home.

c) Photographs must be taken to supplement the written description. The Case Manager should also photograph any areas or items that could cause harm to the child. All photographs must be labeled with the ACV's name, date and time taken, location where the photograph was taken, and name of person taking the photograph. (Refer to ***Work Aid 3, Child Abuse Hotline Tasks and Responsibilities for Referrals Concerning a Child Death or Near Death and Preliminary Near Death***).

d) Photographs of objects are labeled with the name of the object in addition to the information listed above.

e) If responding to reported concerns of environmental neglect and no safety or health issues are present, then pictures of those areas specific to the reported concerns should be taken. This will show that there are no safety concerns.

f) As the family makes progress or lack of progress this will need to be documented in case recordings and through photographs.

g) If the ACV is alleged to have physical injuries or other observable conditions due to the environment, the Case Manager makes a direct observation and provides a written description and photograph of observed conditions and/or injuries, or the lack thereof. At a minimum, the documentation describes details of location, color, length, shape, and size of any injury.

7. See Safety Notice: ***Environmental Safety: Firearm and Medication Storage in Family Homes***

Nutritional Neglect

1. ***Protocol for CPS Categories and Definitions of Abuse/Neglect*** Definition

   A parent or legal custodian/caretaker's failure to provide adequate nutrition to a child. Nutritional neglect occurs when children repeatedly experience hunger for hours or a large part of the day and no food is available. These behaviors may include:

   a) Begging from neighbors for food;

   b) Eating out of garbage cans; or

   c) Constantly stating a need for food.

   Note: In its more severe form, nutritional neglect is the failure to feed a child that result in poor growth which may include the child's weight, height and head circumference falling significantly below the growth rates of average children, malnutrition and non-organic failure to thrive.

2. Case Considerations

a) In addition to underfeeding, Nutritional Neglect may also occur in the overfeeding or lack of preventing over-eating that impacts the health and/or well-being of a child.

b) Unaddressed forms of eating disorders may also fall under the allegation of Nutritional Neglect as well as Psychological Harm.

c) Parents who fail to provide adequate nutrition for their children have often experienced abuse/neglect during their childhood, have had difficulty bonding with their infant, or suffer from depression or certain character disorders.

d) When Nutritional Neglect goes untreated, it can result in continued growth deficits, deficits in cognitive skills (especially language), intellectual and developmental disabilities, and problems in personality development.

e) A medical exam may not be required on all cases but should be considered as an investigative task to support your classification and ensure the child's health needs are addressed.

f) A child being under weight on a growth chart may not be nutritional neglect as there are multiple medical reasons that a child might not be at an appropriate weight. The CPS Case Manager will explore with the healthcare provider if any medical conditions are present that would prevent the child from gaining weight/growing. For infants, weight gain needs to account for pre-maturity as well.

Note: A family's diet that mostly consists of generally recognized unhealthy foods may not rise to the level of Nutritional Neglect but may be an indicator of other issues such as lack of access to health foods whether due to financial resources or geographic "food deserts".

3. Engagement and Interviewing

a) Interviewing parents/caregivers

- Complete a CS-1058, Request for Disclosure of Protected Health Information for each of the child's healthcare providers.
- Explore how the family's financial situation could be impacting the nutritional concerns including income, public assistance, and other community resources. Food stamps or access to a food bank.
- Explore the parent's own understanding of feeding and family culture.
- Explore the child's medical history, including the child's birth weight, was the child full-term or premature, was there any prenatal drug exposure?
- Explore the child's current health, specifically if the child has been seen by a physician recently, when was the date of the child's last physical exam, has the child's growth been tracked by a pediatrician, who is the child's primary care physician, is the child prescribed any medication, does the child have any allergies or medical diagnoses?
- Explore the child's feeding habits, including what and how much the child eats, how often the child eats, if the child has had any changes in diet (breast milk to formula,

regular to soy, formula to whole milk, etc.). If the child is formula fed, have the caretaker show you how they mix the formula and photograph that process.

- Explore where the child stands on meeting developmental milestones and discuss any concerns with the child's healthcare provider.
- Explore family history in terms of weight, growth, and timing of development. For example: Are all children born small but catch up in their growth charts by a certain age? Is everyone in the family known to gain weight easily but has no health issues to report? Explore any food issues, eating disorders, or body image issues the parents may have, or dealt with growing up, that could impact how they feed their child.
- Review immunization card.
- Consider cultural factors such as who eats first, second, etc. as well as who receives what types of food (i.e. those that work are provided more sustaining foods to ensure they can provide for the family).
- Do you have food in the home to prepare meals? Do you have a means to obtain additional food? What would you do if you ran out of food, or what have you done in the past if you ran short on food?
- Does the child require a special diet? If the child requires a special diet, tell me about the diet and what your routine of feeding looks like. Demonstrate your feedings with the child (formula, special diet).
- Do they receive free or reduced meals at school? Breakfast and lunch? Do they receive food from the school to bring home on the weekends (backpack program)?

b) Example questions to ask about child's feeding tubes:

- Who is responsible for the tube feeding? Have those persons been trained on how to properly carry out the feeding?
- How often are the feeding tubes cleaned/replaced? By whom?
- Is the child on a continuous feeding or scheduled feedings?
- Is the child being fed as directed?
- What is the child's diagnosis?
- What is the name of their doctor? Agency?
- Do they attend appointments as scheduled?
- Do they have a home health aide?

c) Interviewing witnesses

- Interview all other persons who may have witnessed the neglect or have relevant information regarding the circumstances of the ACV and family, including referents, other adults in the home or community, professionals, or staff of other agencies.
- Ask school staff if the child is receiving free breakfast and lunch. If not, CPS Case

Manager can assist in helping the family apply for this program.

- Ask daycare providers if they provide meals. If not, do the parents send meals or snacks? If the parents provide formula, are they bringing enough to feed the child consistently throughout the day?
- Topics to explore with the witness:
  - How did the witness learn of the circumstances
  - Last time the witness saw the child
  - What lead the witness to believe that the child is not getting enough food to eat
  - Has the child asked neighbors or others for food
  - The child's current physical condition
  - When was the last time the witness was in the home
  - Amount of food in the home the last time the witness visited
  - Recent weight loss, how much and in what period of time
  - Medical diagnosis of failure to thrive or malnutrition
  - The family's income
  - Participation in food stamps or public assistance
  - The family's access to community resources
  - Improvements to the child's weight once admitted to the hospital

d) Interviewing the child

- Explore with the child their eating habits, including what and how much the child eats, when/how often the child eats, who prepares their food.
- Does the child eat at the same time and location that the siblings, parents/caregivers eat?
- Explore with the child if they have asked other family members or friends for food. Was this because they were not provided food at home?
- Tell me about what you ate yesterday.
- Tell me your favorite foods.
- When did you last eat?
- When did you last eat your favorite food?
- Is there ever a time where you do not have food to eat?
- Are you able to go get food out of the refrigerator or cabinets when you are hungry?
- Who cooks the food in your home?
- Have you told anyone that you feel hungry? What did they say?

4. Assessment of Safety and Risk

    a) Current safety concerns

        - Explore factors such as parent/caregiver alcohol or substance abuse, or untreated mental health disorders, including depression, that could be contributing to the nutritional concerns.
        - Is there formula/food in the home for the child now?
        - Does the child need immediate medical care? What is the child's current physical condition?
        - What is the family's current financial situation and access to resources to be able to provide food?
        - Does the child have any developmental or intellectual disabilities?

    b) Risk and Protective factors

        - Does the school or daycare provide meals to the child?
        - Are the parent/caregivers employed or do they have access to financial resources to provide food?
        - What is the parent/caregiver's level of understanding of children's nutritional needs and development?
        - Explore parental characteristics that would interfere with their understanding of the nutritional needs, such as young age, language barrier, parental developmental delays, single parenthood, large number of dependent children, and low income.
        - Explore parental thoughts and emotions that tend to support or justify maltreatment behaviors.

5. Planning with the Family

    a) Engage the medical professionals to assist in the safety planning process. Will the child be hospitalized? For how long? Will there be any special care or diet required upon discharge? Is there a medical diagnosis.

    b) Consult with the Department's nutritionist

    c) Consider referring the family to the Health Department. The children may need to be referred to Tennessee Women, Infants, and Children (WIC) Program (*https://www.tn.gov/health/health-program-areas/fhw/wic.html*) or the Community Health Access and Navigation in Tennessee (CHANT) Program (*https://www.tn.gov/health/health-program-areas/fhw/early-childhood-program/chant.html*).

    d) Consider utilizing a feeding chart for the child, to record the date, time, and amount of food intake.

    e) Consider weighing the child weekly to track progress.

    f) Important to consult with the involved medical providers for their expertise in case plan

recommendations, including hospital discharge instructions and ongoing dietary needs for the child.

g) The plan should focus on long-term needs as well, such as the parent/caregiver's relationship with the child and any depression or other parent/caregiver mental health needs that have contributed to the nutritional neglect.

h) Services included on the plan should be specific to the health, nutrition, and safety needs of the child and address any other risk factors, safety concerns, and needs identified by the family.

i) Engage parents/caregivers and document all efforts made to involve parents/caregivers to enhance the child's health, nutrition, and physical growth.

6. Documentation

a) The case recordings should clearly identify the neglect and identify the effects of the neglect on the child's healthy and safety.

b) Documentation should include interviews with the child's medical providers, including observations, diagnoses, treatment, and any discharge instructions.

c) Copies of medical treatment records should be obtained, relevant content documented in case recordings, and uploaded to the Electronic Record System.

d) Document any services put in place to reduce risk including services offered, refused and/or court ordered, implementation of services, participation in services, follow up with service providers, and notification to provider that DCS case is closing.

7. Classification and Case Closure

Document the factors surrounding the nutritional neglect that led to the classification. When substantiating, include diagnosis by a medical practitioner.

Medical Neglect

1. *Protocol for CPS Categories and Definitions of Abuse/Neglect* Definition:

A situation in which a child does not receive adequate health care, resulting in actual or potential harm. Medical maltreatment applies to procedures or treatment that a physician or other medical professional deems necessary. Medical neglect does not include elective health care or treatment.

Note: Medical neglect may be considered severe if the absence of medical care endangers the life of the child or is likely to result in severe impairment

2. Case Considerations

a) Investigation of these cases requires collaboration with medical staff and often the Child Protective Investigative Team.

b) Medical neglect does not include elective health care if there is no impact on mental or physical wellbeing, including but not limited to ADHD medication or immunizations.

When there are religious beliefs regarding medical treatment, consult with legal regarding options.

c) When encountering situations involving end of life decisions, consult with DCS Legal.

d) In Tennessee, minors have a right to privacy in their reproductive healthcare decisions, and they may obtain birth control and seek pregnancy and sexually transmitted disease testing without parental consent. Youth, age 14 and older, can seek perinatal care without parental consent as well as seek substance abuse treatment without parental consent.

e) Youth 16 years and older also have the right to provide their own consent and privacy for mental health treatment. Consult with DCS Legal Services when there are questions or court involvement.

3. Engagement and Interviewing

a) With Parents/Caregivers

- Complete *CS-1058, Request for Disclosure of Protected Health Information* for each of the child's healthcare providers.
- Explore the child's medical history, including circumstances of birth (full-term or premature, birth weight, prenatal drug exposure), current diagnoses and medical providers, and upcoming medical appointments.
- Explore the child's current health, specifically if the child has been seen by a physician recently, when was the date of the child's last physical exam, has the child's growth been tracked by a pediatrician, who is the child's primary care physician, is the child prescribed any medication, does the child have any allergies or medical diagnoses?
- Explore the child's feeding habits, including what and how much the child eats, how often the child eats, if the child has had any changes in diet (breast milk to formula, regular to soy, formula to whole milk, etc). If the child is formula fed, have the caretaker show you how they mix the formula and photograph that process.
- Explore where the child stands on meeting developmental milestones.
- Review immunization card to ensure the child's vaccines are up to date.
- Explain next steps clearly, including getting the child to the doctor/hospital for a medical evaluation to ensure the child is in good health.

b) Topics to explore with witnesses:

- How did the witness learn of the neglect
- Last time the witness saw the child
- The child's current physical and/or medical condition
- When was the last time the witness was in the home
- The family's income

- The family's access to community resources
- Improvements to the child's health once admitted to the hospital

c) Interviewing the child:

- Ask the child about their last visit to the doctor
- Tell me what happens when you are sick.
- Do you take medicine? If so, what do you take and who gives you your medicine?
- Explore with the child their medication schedules and who ensures they take their medication.
- When a child does not communicate verbally, the child's physical condition and behavior must be observed.

d) Interviewing the healthcare provider:

- What the child's diagnoses that your office manages?
- Please provide a list of appointments with scheduled, re-scheduled, and no-shows noted.
- What medications and treatment are prescribed/recommended?
- What would happen if the child does not get the medication/treatment?
- Is the family compliant with treatment and services?
- Do you have concerns for the accuracy of the parent/caregiver's history to you?
- What do you see as barriers for the family in healthcare compliance (financial, language, level of understanding)?
- Do you know of any other providers involved in the child's care, and do you receive documentation from those offices? Are the reports consistent with what the family tells you?
- Do you have any concerns for the child if the parent/caregiver transfers the child's care to another provider?

e) Assessment of Safety and Risk

- Current safety concerns
- Explore if factors such as parent/caregiver alcohol or substance abuse, or untreated mental health disorders, including depression, are impacting the ability to seek medical treatment.
- Does the child need immediate medical care? What is the child's current physical condition?
- Does the family's current financial situation and access to resources impact their ability to access necessary medical treatment?
- Does the child have any developmental or intellectual disabilities?

- Complete a case consultation with the regional DCS Nurse.

f) Risk and Protective Factors

- Is there a history within the family of abuse/neglect or a continuous pattern of abuse/neglect that threatens the health or safety of any child?
- Is the child in school/daycare or otherwise visible in the community?
- Are the parent/caregivers employed or do they have access to financial resources?
- Does the child have access to health insurance?
- Does the family have transportation to and from medical appointments?
- What is the availability of family and community supports?
- What is the parent/caregiver's level of understanding of children's medical needs and the treatment required?

g) Planning with the Family

- If immediate harm factors are present, as determined by formal and informal assessments, a safety intervention must be considered.
- Involve the non-offending caregiver in the safety planning process.
- Engage the medical professionals to assist in the safety planning process. Will the child be hospitalized? For how long? Will there be any special care or diet required upon discharge?

h) Developing Permanency Plans with the Family

- The goal is to promote the health and safety of the child by strengthening the ability of families to effectively address the medical needs.
- Important to consult with the involved medical providers for their expertise in case plan recommendations, including hospital discharge instructions and ongoing needs for the child.
- The plan should focus on long-term needs as well, such as the parent/caregiver's relationship with the child and other parent/caregiver mental health needs.
- Services included on the plan should be specific to the health and safety needs of the child and address any other risk factors, safety concerns, and needs identified by the family.
- Engage parents/caregivers and document all efforts made to involve parents/caregivers to enhance the child's health and safety.

i) Documentation

- The case recordings should clearly identify the medical neglect and identify the effects of the neglect on the child's health and safety.
- Documentation should include interviews with the child's medical providers, including observations, diagnoses, treatment, and any discharge instructions.

- Copies of medical treatment records should be obtained, relevant content documented in case recordings, and uploaded to the Electronic Record System.
- In cases of severe medical neglect, documentation should include collaboration with CPIT partners and outcome of CPIT team meeting.
- Document any services put in place to reduce risk including services offered, refused and/or court ordered, implementation of services, participation in services, follow up with service providers, and notification to provider that DCS case is closing.

j) See Safety Notice: TennCare Case Management

Educational Neglect

1. *Protocol for CPS Categories and Definitions of Abuse/Neglect* Definition:

   Repeated failure of the parent or legal custodian/caretaker to meet the child's educational needs. This allegation applies to:

   a) Children legally mandated to be in an educational program through eighteen (18) years of age. When applying this allegation to children twelve (12) and over, it should only be considered after the inability of the school to engage the parent or legal custodian/caretaker to improve the child's school attendance.

   b) Parent or legal custodian/caretaker failure to enroll a child in school or failure to register a home-schooled child with the Board of Education.

      Note: This allegation is not appropriate for reports of children who willfully refuse to attend school.

      Note: This allegation is not appropriate unless the school has demonstrated attempts to correct the situation under the Three Tier Progressive Truancy Intervention Plan (*Attendance Policy 6200*).

2. Case Considerations

   a) Mandatory School Attendance applies to children ages 6 up to their 18th birthday.

   b) The child's age and developmental status must be considered when evaluating the impact of the educational condition of the child.

   c) A child with an underlying condition that is negatively affecting their learning must be included in an Individual Educational Plan (IEP) completed by the schools and must meet IDEA (Individuals with Disabilities Education Act) and FAPE (Free Access Public Education).

   d) The local Education Provider must complete their 3 Tier Plans to address truancy, or it will not meet criteria for Educational Neglect.

   e) Beginning with the 2021-2022 school year, progressive truancy plans must include a first tier of truancy prevention that is applicable to all enrolled students, and a second and third tier of truancy intervention required for students who have accumulated a

minimum of five (5) days of unexcused absences. (Tenn. Code § 49-6-3009)

f) Tennessee Board of Education Three Tier Truancy Intervention

- Tier I:
  - A conference with the student and the student's parent/guardian, or other person having control of the student;
  - An attendance contract, based on the conference, to be signed by the student, the parent/guardian, or other person having control of the student, and the school leader or designee. The contract shall include:
    - A specific description of the school's attendance expectations for the student;
    - The period for which the contract is effective; and
    - Penalties for additional absences and alleged school offenses, including additional disciplinary action and potential referral to juvenile court; and
  - Regularly scheduled follow-up meetings, which may be with the student and the parent/guardian, or other person having control of the student, to discuss the student's progress
- Tier II:
  - If the student accumulates additional unexcused absences in violation of the attendance contract required under Tier I, the student will be subject to Tier II. Tier II shall include an individualized assessment by a school employee of the reasons the student has been absent from school. This may result in referral to counseling, community-based services, or other in-school or out-of-school services to address the student's attendance problems.
- Tier III:
  - If the truancy interventions under Tier II are unsuccessful and the student continues to accumulate additional unexcused absences, Tier III shall be implemented. Tier III may consist of one (1) or more of the following interventions, as determined by a team formed by the school:
    - School-based community services;
    - Participation in a school-based restorative justice program;
    - Referral to a school-based teen court; or
    - Saturday or after school courses designed to improve attendance and behavior.
    - Tier III interventions shall address student needs in an age-appropriate manner.

g) For children enrolled in Home School and Virtual School programs, the provider should be contacted for compliance and verification of attendance and participation, as well as any truancy protocols.

- A “home school” is a school conducted or directed by a parent or parents or a legal guardian or guardians for their own children. Public school facilities may be used by home school participants with the approval of the principal of the school, but this permissive authority shall not be construed to confer any right upon the participants to use public school facilities. If approved, use shall be in accordance with rules established by the local board of education.
- Parents desiring to home school their own children may do so by choosing one of the following three options:
  - Independent Home School
  - Church Related Umbrella School
  - Accredited Online School
  - See Tennessee Code § 49-6-3050

3. Engagement and Interviewing

   a) When assessing the educational environment, look for the following that could be considered within the parameters of Educational Neglect:

   - Has the child missed an excessive number of days without a doctor’s note or other approved absences recognized by the school?
   - Is there an impact of missing school that is affecting the grades of the child and/or the child is at risk of failing or being held back in the same grade for another year?
   - Is the child is receiving Special Education Services due to a learning disability, that the school must make accommodations or modifications to address, are these sufficient to meet the child’s educational success?
   - Are the parents refused to meet with the school or provide explanations for why the child has not been attending school?
   - Is the parent at a cognitive level to understand the seriousness of the concerns, or do they potentially need an advocate to assist them in understanding the concern?
   - Has the child been sent home from school on numerous occasions due to health concerns by the school nurse? Poor hygiene, sickness, lice, lack of appropriate clothing, etc. that could affect the health and wellbeing of a child. This could lead to the spread of illnesses and diseases. It can also cause a negative impact on the child’s mental health (depression, anxiety, suicide).
   - Does the child have a mental health diagnosis that requires medication that is not being provided to assist the child with their attention span? Does the school feel the child needs medication, but the parent is not in agreement? Or if the child receives medications, is it negatively impacting the child’s ability to learn? (i.e.: Sleeping class, excessive fidgeting, unable to focus or remain on task)
   - Transportation limitations: Does the child ride a bus or is brought to school via parent’s motor vehicle.

- Is the child/ren enrolled in a home school program? Are they attending and participating with making advancements in learning? Can verification be obtained?
- Is the child/ren enrolled in a virtual school program? Are they attending and participating and making advancements in learning? Can verification be obtained?
- If the family is experiencing housing instability or homelessness, is the school refusing to allow the parent to enroll the child, or the parent does not know how to enroll the child in a school, due to lack of stable housing?

b) When interviewing a child about educational neglect consider the following:

- How does the child get to school (bus rider/car rider)?
- Who gets them up and ready in the morning? Or are they responsible for getting themselves ready and off to school?
- What sorts of things cause them to miss school or be tardy?
- Are they frequently ill or tired a great deal of the time?
- If they have school age siblings, who is responsible for getting them ready?
- Is an older sibling or the child responsible for the younger ones?
- Does the child have any special needs or chronic illnesses that complicate school attendance?

c) When speaking with the alleged perpetrator or caregiver, one will want to ask them:

- Are there any problems that have specifically caused the concern for Educational Neglect?
- What current supports do they have to ensure the child attends school and is learning?
- What are their thoughts on the child's characteristics, strengths, condition, and developmental needs?
- Who is involved in the care of the children?
- Who is responsible for getting the children to school?
- What is their understanding of the child's educational needs? IEP? ETC?
- How is your child doing in school? Does your child enjoy attending school?
- How is your child's school attendance?
- Is the child enrolled in school? What school? If not, when did the child last attend school?
- How many days of school has the child missed this year? Were any of these days excused? What sorts of things cause them to miss school or be tardy?
- Has the child failed a grade in the past due to truancy?
- If the child is home schooled, what is the name of the home school organization that

the child is enrolled with? If the child is home schooled who is responsible for teaching the curriculum?

- How does the child get to school (bus rider/car rider)? Who gets them up and ready in the morning? Or are they responsible for getting themselves ready and off to school?
- Speak with witnesses, collaterals, other professionals, or agencies. It is especially important in Educational Neglect to ensure that School staff are involved and interviewed which may include:
- What is their professional opinion about the situation regarding the education?
- What are their thoughts on the parent/caregiver's level of functioning and their ability to understand the situation?
- Has the family been involved with truancy court or the Family Crisis Intervention Team? (age 12 and older)
- What is the explanation given for lack of attendance?
- How has the school system attempted to engage the family to improve the child's school attendance?
- Has the school system implemented a Truancy Intervention Plan?"
- Has the family cooperated with any services offered?

4. Assessment of Safety and Risk

a) Identify and build on the caregivers' strengths that are identified during the assessment process. These strengths can be reinforced, and interventions planned to build on those strengths.

- Possible Caregiver Strengths:
  - Motivation to improve and make changes so they're children can advance in education
  - Shows concern for children and their education
  - Willingness to learn ways to help children improve their educational standards
  - Resourceful and knows about community/school programs available to help
  - Cooperative with the school system and working towards assisting in their child's learning
- Possible ACV Individual Risk Factors:
  - Children's age and developmental status
  - Special needs
  - Other Abuse/Neglect at home
  - Increased responsibility to care for younger siblings

- Possible AP Individual Risk Factors:
  - Caregiver's lack of understanding of child's needs, child development or educational skills.
  - Caregiver has limited education or low cognitive functioning.
  - Caregiver did not attend school on a regular basis and doesn't deem it as important.
  - Caregiver has a substance abuse disorder.
  - Caregiver has mental health diagnosis or is displaying signs or mental illness that inhibits getting child up for school or completing homework.
- Possible Family Risk Factors:
  - Lack of family support and resources when assistance is needed with the school
  - Family Stress (Divorce or separation, Domestic Violence)
  - Single parent household with lack of supports
  - Household structure (others living in the home that are not family) that makes meeting educational needs difficult
  - Lack of reliable transportation or access to transportation when needed.
- Possible Community Risk Factors:
  - Community violence
  - School violence
  - Community/culture does not value formal education
  - Bullying by other students/parents/teachers
  - Lack of resources to help with educational needs of children
- Possible Family Protective Factors:
  - Supportive family environment and social networks that reinforce the value of education
  - Concrete support for basic needs
  - Nurturing parenting skills
  - Stable family relationships
  - Household rules and child monitoring regarding education and learning
  - Parental employment
  - Parental education
  - Adequate housing that is stable and remains consistent
  - Access to community resources that promote educational advancement

- Caring adults outside the family who can serve as role models or mentors and supports for the family.

♦ Possible Community Protective Factors:

- Communities that support parents and take responsibility for preventing educational limitations.
- Ease of access to services to and sufficient providers for tutoring and learning disabilities
- Access to knowledgeable advocates who specialize in educational problems
- Values knowledge and promotes continuing education

5. Planning with the Family

a) If there is a concrete need utilize school resources and supports as well as those within the family. Talk with the school social Case Manager about services they can refer the family for additional services.

b) Reach out to your resource linkage coordinator to determine what services and assistance is available to the family based on their needs.

c) Complete a CSR (Case service request) for usage of funds to help address and assist the family's needs.

d) Examples of possible services:

♦ Public Transportation

♦ TN Voices for Children

♦ STEP – (Support Teaching Exceptional Parents) for children with special needs

♦ Tutoring at school

♦ After school programs

♦ Peer tutoring availability

6. Documentation

a) The attendance and underlying issues must be described in the case recordings. How many days the child has missed. And has the school exhausted the 3 Tiers.

b) The documentation should clearly identify how many days the child has been absent, if there is an IEP, what steps the school has taken as well as those of the parent.

c) Educational Records should be obtained to include attendance sheet and grades. Any other documentation pertinent to the child's education should also be obtained. These could include:

♦ Individual Education Plan,

♦ Special testing that has been requested or completed,

♦ Documentation of any special needs the child may have if applicable,

- Attendance and other records from any previous schools if applicable,
- Verification of Doctors notes, and/or
- Documentation of any disability or chronic illness which complicates school attendance.

d) As the family makes progress or lack of progress this will need to be documented in case recordings and through records.

e) The Case Manager will maintain contact with the school, juvenile court (as applicable), and family to monitor truancy.

7. Classification and Case Closure

a) Documentation to include attendance records and other verification that the child is enrolled in and attending school regularly. As well as uploading the school verification items into the case.

b) Risk factors been reduced significantly so that the caregivers can protect their children and meet their developmental needs.

c) Caregiver understanding the effects that Educational Neglect can have on the children.

Lack of Supervision

1. *Protocol for CPS Categories and Definitions of Abuse/Neglect* Definition:

Failure to provide adequate supervision, by a parent or other legal custodian/caretaker, who is able to do so. A lack of supervision allegation or determination means that:

a) The child has been placed in a situation that requires actions beyond the child's level of maturity, physical ability, and/or mental ability; or

b) Caregiver inadequately supervises a child. The caregiver is with the child, but is unable or unwilling to supervise (e.g., the caregiver is under the influence of alcohol or drugs, is depressed, sleeps during the day or has inadequate parenting knowledge or skills).

c) Any registered sex offender residing in the home with unrelated minor children or victim of offender and/or caregiver knowingly resides with and/or allows children to be unsupervised with a registered sex offender.

2. Case Considerations

a) Lack of supervision occurs when a parent or other legal guardian fails to provide adequate supervision.

b) Inadequate supervision occurs when a child is placed at a significant and imminent risk of likely harm due to a parent's or caregiver's blatant disregard of parental or caregiver responsibilities.

c) Any registered sex offenders residing in the home with unrelated minor children or victim of offender and/or caregiver knowingly resides with and/or allows children to be unsupervised with a registered sex offender.

d) Concerns that children in a congregate care facility were able to engage in sexual activity regardless of age of children and/or if initially reported as consensual, should be assigned as lack of supervision in addition to the sexual abuse allegation (see DCS Policy *18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse and Sexual Harassment Incidents and Prison Rape Elimination Act (PREA)*.

e) Caregiver recklessly or repeatedly disregards law related to child safety. (e.g. reckless driving with a child in the car, DIU with a minor in the vehicle, failure to use appropriate car seats).

3. Engagement and Interviewing

a) When interviewing a child about lack of supervision consider the following:

- The age of the child left alone, including an assessment of the child's developmental stage, capability, and level of maturity.
- Whether the child was given a phone number for the parent or caregiver, an emergency number, or other means of contacting the parent, caregiver, or other source of assistance at the time the child was left without care and support, including necessary supervision.
- Whether the child could make an emergency call.
- The child's level of preparedness for being left alone at home, outside or in the community and the child's feelings about being left alone.
- The frequency in which the child is left alone.
- Specific conditions regarding the surroundings of the child, including whether there were any dangerous conditions that were known, or should have been known to the parent or caregiver.
- If the case involves a registered sex offender, explore the relationship and access this offender has to the child.

b) Interviewing parents/caregivers

- What is the parent/caregiver thoughts about adequate supervision?
- Who is involved in the care of the children?
- When sex offenders are involved, review the stipulations of the offender's restrictions/conditions

  Note: If any clarification is needed, the CPS Case Manager should contact the local law enforcement agency that maintains the Sex Offender Registry to obtain the offender's restrictions/conditions.

- How long has the child been unsupervised?
- Who is supposed to be supervising the child?
- Who is involved in their care?
- How often does this happen? Is it a certain time of day or night?

- Where is the parent/caregiver?
- Has anyone else seen the child left alone?
- Does the caregiver supervise child appropriately considering the child's age and mental capacity?
- Does the child wander outdoors alone?
- Does the child play with hazardous materials when unsupervised?
- Are the children placed in situations that require actions beyond the child's level maturity?
- What is the plan or way for the child to contact the parent/caregiver in case of an emergency?
- Is the parent/caregiver willing/able to care for the child? If not, why?
- Gather information about relatives, friends, kin that could assist with supervision.

c) Interview witnesses

- Interview all other persons who may have witnessed the neglect or have relevant information regarding the circumstances of the ACV and family, including referents, other adults in the home or community, professionals, or staff of other agencies.
- Topics to explore with the witness:
  - How did the witness learn of the neglect/ Lack of Supervision?
  - Last time the witness saw the child
  - The child's current physical and/or medical condition
  - When was the last time the witness was aware of the child being left alone?
  - Parents/caregivers behaviors, substance use or mental health concerns
  - What specific concerns do they have for the child/family
  - What are their thoughts on the parent/caregiver's level of functioning and their ability to understand the situation?

4. Assessment of Safety and Risk

a) Factors to be considered:

- Is there a history within the family of abuse/neglect or a continuous pattern of abuse/neglect that threatens the health or safety of any child?
- Duration and frequency of time of the occurrence in which the child was left without care and support, including necessary supervision.
- Age, mental health capacity and maturity level of the child.
- Time of day or night the child was left without care and support, including necessary supervision.

- Weather conditions, including whether the child was left in a location with adequate protection from the natural elements, such as adequate heat, light or shelter.
- Condition or location of the place where the child was left without care and support, including necessary supervision, all assessed in the context of how long the child was left alone.
- The location and accessibility of the parent or caregiver to the child.
- The physical distance the child was from the parent or caregiver at the time the child was without care and support, including necessary supervision.
- The child's access to or ability to access provisions necessary for his or her physical well-being, such as food, water, necessary medication, or medical treatments. Whether the child's movement was restricted.
- The age, physical and mental capabilities of the caregiver.
- Whether the child was caring for other children and the age of the child left in charge and the ages of the children being cared for. The number and ages of the children left at the location.
- Parent or caregiver's intent to leave the child alone, including whether the decision was planned or the result of an emergency, mistake, or miscommunication.
- Children who became unattended without a caregiver's knowledge or awareness (e.g., a child who accidentally wanders off or escapes the home temporarily).
- Other factors that endanger the health and safety of the child (whether drugs or alcohol were involved).
- Other factors that demonstrate that the parent or caregiver took other precautionary measures to prevent or mitigate the risk of any likely harm to the child.

5. Planning with the Family
   a) Interventions should be structured to increase protective factors and decrease risk factors identified in the family assessment process. That information can be used to tailor the intervention to help them meet the children's basic needs, to eliminate risks of child neglect.
   b) Work with the family to address and eliminate the supervision concerns.
   c) Identify safety plans regarding the contact the registered sex offender can have with the child.
6. Documentation
   a) The case recordings should clearly identify the neglect and identify the effects of the neglect on the child's health and safety.
   b) Documentation should contain detailed entry of information obtained from the child, parent/caregiver, siblings, and all witnesses.

c) Copies of medical treatment records should be obtained, relevant content documented in case recordings, and uploaded to the Electronic Record System.

d) In cases of severe lack of supervision, documentation should include collaboration with CPIT partners and outcome of CPIT team meeting.

e) Document any services put in place to reduce risk including services offered, refused and/or court ordered, implementation of services, participation in services, follow up with service providers, and notification to provider that DCS case is closing.

7. Classification and Case Closure

a) Risk factors been reduced significantly so that the parents/caregivers can protect their children and meet their developmental needs.

b) The parents/caregivers have knowledge and access to relevant support services and information.

c) The parents/caregivers understand the importance of ensuring that their children always have adequate supervision.

Abandonment

1. *Protocol for CPS Categories and Definitions of Abuse/Neglect* Definition:

a) Deliberate absence of the parent or other legal custodian/caretaker for an extended period with no plan or provision for the child's care. It may include:

- Abandonment of the child in the child's own home, in day care or in substitute care;
- Abandonment of the child in a car, on the highway, or in a public place;
- Child left in the care of a suitable caregiver but without proper planning or consent. The caregiver leaves the child but does not return when scheduled or has a history of leaving the child without providing essentials for care (e.g. diapers, formula);
- Newborn infants who are aged 45 (forty-five) days or younger and voluntarily delivered by the infant's mother to a designated facility as defined by TCA 68-11-255, Procedure for Surrendering Custody of Unwanted Infant Without Criminal Liability, per TCA 36-1-142) does not apply to the definition of abandonment. Procedures are followed as outlined in guide.

b) Exception: Parents/caretakers with unruly children who exhibit unmanageable behavior and require intervention services are referred to Family Crisis Intervention Program (FCIP) services. (Refer to DCS Policy *14.19, Family Crisis Intervention Program*).

2. Case Considerations

Note that sometimes parent/legal guardian deaths may be screened in as Abandonment. When that happens, consultation with a supervisor for a trauma informed response including discussing how and who is to inform the child and surviving family members.

3. Engagement and Interviewing

a) Interviewing the Alleged Perpetrator:

- Develop questions around questions for the for AP of why caretaker feels they can no longer take care of the child.
- Is there a custody agreement between the parents?
- Who has legal custody of the child?
- Why does the child have a different last name than either parent? (Assuming both mother and father's identities are available)
- Did you make any prior arrangements with the current caregiver? If so, what are the arrangements?
- Do you provide money or any type of support to the current caregiver?
- Where is the child now?
- Is the child safe with the current caregiver?
- What is the relationship between the child and the current caregiver?
- How long has the child been with the current caregiver?
- When was the last contact made with the child?
- What is your reasoning for the leaving the child?
- Has any support been provided to help assist in the care of the child in your absence?
- How long is the current caregiver willing to keep the child?
- Does the child have a medical problem that require the care of a doctor?

b) Interviewing the Child

- When is the last contact you had with your parent/caregiver?
- Where did your parent/caregiver say they were going the last time you saw them?
- Have you been left alone before?
- What did you do to take care of yourself when you were left alone?
- How long were you left alone before?
- Do you feel safe with the current caregiver?
- What is your relationship with current caregiver?
- How long have you been with the current caregiver?

c) Interviewing the Current Caregiver

- How long is the current caregiver willing to keep the child?
- When did the child first come to live in the home?
- Where does the child say they have been all this time?

- Where do you think the child has been all this time?
- Does the current caregiver have a Power of Attorney?
- Why did the child not live with you until this time?
- When was the last contact with the legal guardian? What type of contact?
- What is the address and phone number for the legal guardian?
- Can the current caretaker contact the parent or guardian in case of emergency? How?
- Does the child have any medical problems that require the care of a doctor?

4. Assessment of Safety and Risk

   a) Current Safety Concerns

   - Explore factors such as parent/caregiver alcohol or substance abuse, or untreated mental health disorders, including depression.
   - What is the child's current mental health condition? Does the child need immediate mental health assessment?
   - Does the child have any developmental or intellectual disabilities?

   b) Risk and Protective Factors

   - Is the child in school/daycare or otherwise visible in the community?
   - What is the utilization of family and community supports? Are there caring adults outside the home who can serve as role models or mentors for parents/child?
   - What is the parent/caregiver's level of understanding of children's needs, child development, and parenting skills?
   - Do the parents/caregivers accept responsibility for the behavior?
   - Explore parental characteristics such as young age, low education, single parenthood, large number of dependent children, and low income.
   - Explore parental thoughts and emotions that tend to support or justify maltreatment behaviors.
   - Explore family stressors such as: separation or divorce, and violence, including intimate partner violence, poor parent-child relationships, child behavioral issues and other negative interactions.

5. Guidance to CPS Staff for Anonymous Voluntary Abandonment of Unharmed Newborn Infant (Safe Haven)

   a) Anonymous Voluntary Abandonment cases meeting statutory requirements.

   - The newborn infant must be aged 45 (forty-five) days or younger (as determined within a reasonable degree of medical certainty) and must not have been harmed (including drug exposure) by the statutory parent, as per Tenn. Code Ann. § 68-11-

255(a)(6) and (b)(1), and

- The birth mother must have left the newborn infant by voluntary delivery to any hospital as defined by TCA § 68-11-201. Birthing center as defined by TCA § 68-11-201, community health clinic, out-patient "walk-in" clinic, fire department that is staffed twenty-four (24) hours a day, law enforcement facility that is staffed twenty-four (24) hours a day or emergency medical services facility.

  Note: The mother's return to the hospital grounds only invalidates the statutory requirements when she makes an attempt or expresses an intention to make contact with or regain care and control of the infant. A mother who returns for a separate medical appointment does not invalidate the statute.

b) Response Protocol

- Response Priority Level – Priority I Response (as outlined in DCS Policy *14.2, Screening, Priority Response and Assignment of Child Protective Services Cases*).
  - Upon notification by the medical facility, the Case Manager will immediately call in a report to Central Intake.
  - Assume the care, custody and control of the newborn infant.
- Information Gathering (Investigation)
  - The Case Manager:
    - Meets with the medical professional who received the newborn infant at the facility;
    - Determines the day and time the infant was brought to the medical facility;
    - Obtains written proof of the newborn infant's age and medical condition from the medical professional charged with making such determinations;
    - Seeks any information about the infant and the birth mother that can be provided by the person making the report; and
    - No contact is sought with the birth mother, birth father or any other relatives so long as the facts support the criteria outlined in the original referral.

      Note: Even if identifying information for the parents is provided to the department, the department is responsible for maintaining the confidentiality of the information per statute TCA § 68-11-201.
- Classifying the Case
  - The Case Manager records the case as an alleged abandonment.
  - The case will not be referred to Child Protective Investigative Team (CPIT).
  - CPS classifies the allegation of abandonment as "unsubstantiated."
  - Reported through the Central Intake Unit
- Legal Publication Notice

- Within ten (10) days of receipt of an infant, the family service Case Manager gives notice once a week for four (4) consecutive weeks in a newspaper or other publication of general circulation in the county in which such voluntary delivery occurred.
    - The department also gives such notice in any other county for which there are any facts known to the department that reasonably indicate the infant's mother or father may be so located.

      The notice includes information to provide an opportunity for the putative father to claim paternity and for the mother to revoke voluntary delivery. Such notice describes the infant, identify where and when voluntary delivery occurred, specify how and who to contact for follow up, and provide any other relevant information.

- Legal Referral
    - The Case Manager coordinates and cooperates with the local DCS Regional Attorney to file the appropriate court documents and attends court hearings as necessary.
- Placement of Infant
    - For those infants referred within normal working hours (8:00 a.m. – 4:30 p.m.), the (CPS or FSW) Case Manager make an immediate referral to the Permanency Specialist team.
    - After normal business hours, on holidays or on weekends, the (CPS or FSW) Case Manager first facilitate the placement of the newborn infant in a foster home. On the first working day, the (CPS or FSW) Case Manager make an immediate referral to the Permanency Specialist team.
    - At the point of referral, the Permanency Specialist immediately convenes a Placement Review Team Meeting, select the family for the child and place the child in a legal risk home in accordance with the Adoption Best Practice Procedures Manual, “Services to the Child V. Considering Direct Placement of Newborns.
    - The Placement Review Team in these cases should consist of the CPS Case Manager, Permanency Specialists, FSW Case Manager, FSW Team Leader, RPS Case Managers, and Placement Specialists.
    - The potential adoptive placement must be told:
        - The child is not yet free for adoption, but DCS intends to pursue an adoptive placement.
    - If it is determined that it is the child’s best interest to be adopted, then it is unlikely that a newborn is eligible for adoption assistance. This also means that the adoptive family is responsible for paying all legal fees to finalize the adoption.

- The child may be placed in or remain in a foster care setting for a period of seventy-two (72) hours to allow for the selection of the legal risk placement, allow time to present the child information to the legal risk family, and to allow the family to make an informed decision about the child presented to them. If for any reason the placement of the child cannot be made within this seventy-two (72)-hour period, a placement plan must be presented to the Regional Director for review and approval. The placement plan must indicate timelines and specific actions to be taken to reach legal risk placement.

- Follow-Up
  - The Permanency Specialist and FSW continue to document whether the birth mother has made any contact with the Department or whether she has revoked her voluntary delivery of the child.
  - Within ten (10) days of the voluntary delivery by the mother to the medical facility, the Department publishes a notice in the newspaper seeking to notify the child's father of his opportunity to file with the putative father registry, notify the mother of her right to revoke the voluntary delivery of the child, and states that failure to seek contact with the infant through the Department or to revoke the voluntary delivery within thirty (30) days of the last publication constitutes an abandonment of the infant.
  - The Permanency Specialist and FSW staff the case with the DCS attorney after thirty (30) days (counted from the date of the mother's voluntary delivery) to determine the next step in the legal process.
  - Any contact by the mother or father or by any person claiming to be the mother or father must be reported immediately to the local DCS Regional Attorney.
  - If the mother or father wishes to revoke their voluntary delivery, the case is immediately staffed with the local DCS Regional Attorney and consideration is given to all legal options including the filing of an emergency petition if there are serious concerns about the parents.
- Abandonment Cases not meeting statutory requirements
  - If the facts of the case as to the infant's age or condition so dictate or if either of the birth parents revokes the voluntary delivery of the infant, the case is handled according to DCS Policies *14.4,CPS: Locating the Child and Family* and *14.6, Child Protective Services Case Tasks and Responsibilities*.
- Anonymous Voluntary Abandonment information for parent(s)
  - Information regarding *voluntary abandonment* is on the Intranet.

Child Sexual Abuse

1. *Protocol for CPS Categories and Definitions of Abuse/Neglect* Definition:

a) Child sexual abuse occurs when a child who is under the age of thirteen (13) or was under the age of thirteen (13) when the abuse occurred or a child is age 13-18 and meets the relationship criteria per policy, and the child is involved in intentional sexual acts that produce sexual arousal and/or gratification for the perpetrator including:

- Explicit sexual acts;
- Vaginal, oral, anal or digital penetration with or without the use of an object;
- Touching, fondling, molestation or intentional contact, either directly or through the clothing, with genitals, anus, groin, inner thigh, buttocks or breasts of child or perpetrator. This also includes when adolescents or adults instruct children to engage in such behaviors with each other;
- Indecent exposure and voyeurism; and
- Intentionally exposing a child to sexually explicit material.
- Any acts defined as sexual abuse by the Prison Rape elimination Act (PREA), (Pub. L. No. 108- 79 (2003) and the PREA Standards, 28 CFR Part 115. (see DCS Policy *18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse and Sexual Harassment Incidents and Prison Rape Elimination Act (PREA)*.
- Knowingly performing acts to seduce, solicit, lure, or entice a child to commit any unlawful sexual act or any sexual abuse as defined in TCA 37-1-602(a)(3). (Grooming behaviors such as subtle actions that escalate for the purpose of introducing sexual content or touching, manipulation to ensure the ACV's silence or participation, creating opportunities for inappropriate contact, giving gifts or privileges to build a false sense of trust, sharing sexual images or having inappropriate discussions to desensitize the ACV.)

b) Sexual behaviors or situations in which the motivation may or may not be sexual, but there is a clear sexual component such as:

- Taking pictures or videos of children engaging in sexual activities or in sexually explicit poses;
- Making children available to others for sexual purposes;
- The sexual gratification or benefit of an adult;
- The solicitation of a minor by requesting or inviting a minor to engage in sexual activity, even if the solicitation did not result in a sexual act. The solicitating communication can include spoken word, electronic mail or internet services, and text or photo messages.
- Use of a child for prostitution; and
- Caregiver has knowledge or reasonable suspicion of child sexual abuse by another person and intentionally fails to intervene or protect child.

Note: Childhood behavior that is indicative of age-appropriate curiosity and/or development between similarly aged and/or functioning on commensurate developmental level is not considered sexual abuse.

Note: For the purposes of a child in the custody of DCS placed at a residential facility, a "person living in the child's home" includes a person living in a residential setting with the child.

c) Commercial Sexual Exploitation of a Minor (CSEM)

- The use of any person under the age of eighteen (18) as defined in, numbers one (1) and two (2) of this section in exchange for anything of value either directly or indirectly. Force, threat or coercion is not a factor for Commercial Sexual Exploitation of a Minor (CSEM).
- For screening purposes, a report may be submitted for investigation of CSEM without direct allegations of Child Sexual Abuse as defined above when a reasonable suspicion of CSEM exists which may include one (1) or more of the below risk factors:
  - Chronic Runaway;
  - Large amounts of cash or prepaid cards;
  - Dramatic increase of material possessions with no other explanation;
  - Hotel keys, receipts, etc.;
  - Older " boyfriend" or overtly concerned/controlling male OR FEMALE;
  - Personal items don't reflect living situation;
  - Multiple Sexually Transmitted Infections (STI's);
  - Unexplained injuries; and/or
  - Significant change in behavior.
- Knowingly performing acts to seduce, solicit, lure, or entice a child to commit any unlawful sexual act or any sexual abuse as defined in TCA 37-1-602(a)(3) and Prison Rape elimination Act (PREA), (Pub. L. No. 108- 79 (2003) and the PREA Standards, 28 CFR Part 115. (see DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse and Sexual Harassment Incidents and Prison Rape Elimination Act (PREA). (Grooming behaviors such as subtle actions that escalate for the purpose of introducing sexual content or touching, manipulation to ensure the ACV's silence or participation, creating opportunities for inappropriate contact, giving gifts or privileges to build a false sense of trust, sharing sexual images or having inappropriate discussions to desensitize the ACV.)

  Note: Sexual abuse is always considered severe

2. Case Considerations

a) Most children are sexually abused by family members or close family friends.

b) Only 2% to 5% of disclosures made by children are false.

c) Many children never disclose their abuse. Common reasons include:

- Threats have been made by their abuser

- They are afraid of the consequences that could come with disclosing (such as being removed from their family)
- There has been a lack of opportunity or haven't felt safe enough to disclose
- There is a lack of understanding that they are being abused
- Despite the abuse, they have a relationship with and even love their abuser.

d) Disclosures are a process, not an event and can often be convoluted and impacted by developmental understanding of the abuse.

e) 23% of children who disclose sexual abuse later recant. Children are more likely to recant when they are younger, abused by a parent figure, or lacked support from the non-offending caregiver. Studies show that most children who recant are telling the truth when they originally disclose. Additional, children may recant as they falsely accept responsibility and/or blame for the actions that have followed their initial disclosure that are designed to ensure their safety but also place stress on their family situation.

f) Children with disabilities are at higher risk for sexual abuse due to increased isolation, communication barriers, and support needed for daily living activities.

3. Engagement and Interviewing

a) When speaking with the child, acknowledge this is a difficult conversation. Avoid any statements that would blame the child. Be aware of your own reactions, maintain a calm demeanor.

b) When meeting with the family, fully explain the CPS process, CPIT team, and investigative process for child sexual abuse cases.

c) Acknowledge that the family and child victim may have dual relationships with the alleged perpetrator. Be careful not to demonize the alleged perpetrator.

d) Partnering with the Non-Offending Parent/Caregiver

- Provide time and space for them to discuss their feelings, including any denial or disbelief, their own trauma, and possible manipulation by the offender.
- Provide the non-offending caregiver with information on recognizing trauma in their child, and some methods they can use to address it.
- Provide information to non-offending caregivers around the facts about child sexual abuse.
- Explain the importance of supporting the child.
- Ask how the siblings and extended family members may respond to the allegations.
- Discuss strategies for long term prevention and safety.
- Evaluate their ability to protect the child in terms of financial resources, mental stability, and informal/formal support systems.

e) Coordinate interviews with CPIT partners including the usage of minimal facts, forensic

interviews, and alleged perpetrator interviews.

- Evaluate whether to age, type of incident, gender or other trauma-responsive indicators the timing, method and person to conduct the interview(s).

f) Alleged Child Victim Interviews

- Defer any discussion with the ACV about sexual abuse prior to the forensic interview taking place. Use minimal facts to obtain immediate safety information when appropriate. If a child makes a disclosure during the minimal facts, allow them to discuss the allegations with you without interruption.
- Interviews with children should be done when alleged perpetrator is not present or where the abuse occurred, if possible. Full global assessment of risk and safety should still be conducted.
- Minimal Facts interviews are done to yield information necessary for immediate protection. If the safety information can be obtained from other sources, there is no need for the minimal facts interview. (See additional instructions regarding minimal facts interviews in the child interviewing section)
- A forensic interview is a single session, recorded interview designed to elicit a child's unique information when there are concerns of possible abuse in a supportive, non-leading, and legally defensible manner. These are conducted by trained forensic interviewers at Child Advocacy Centers.
    - DCS and LE should be present to witness the interview being conducted.
    - Coordinate with your CPIT to schedule the FI for the ACV and possibly other children living in the home
    - The alleged perpetrator cannot bring in the ACV for the FI. Be thoughtful about having only supportive caregivers bring the child to the FI.
    - FIs may not be able to be used in cases where the child is a perpetrator or the child is unable to verbally communicate due to age or disability.
    - After the FI, DCS should speak privately to the non-offending caregiver about the child's disclosure or lack of disclosure, the impacts on safety, and any next steps for the case.
    - If a parent refuses to take a child to the forensic interview, try to engage them in understanding why. Consult your supervisor, CPIT team, and legal for next steps.

g) Other children living in the home

- CPIT team members should discuss and consider scheduling forensic interviews for other children living in the home to identify if they are also a victim or if they can provide any corroborating information.

h) Non-Offending Caregivers

- Interview the non-offending caregivers when the alleged perpetrator is not present or in the vicinity.

- Use interview questions to gauge their response to the abuse, any corroborating details, and observations.
- Is the non-offending caregiver aware of the abuse? If so, what is their response?
- Has the child made a disclosure of sexual abuse?
- Identify the first date of disclosure as well as any hints of disclosures the child tried to make in the past.
- What does the child say happened?
- Where did the reported abuse take place? (Address, city, county)
- When did the abuse last happen and how often did it occur?
- Does the alleged perpetrator have current access to the child or other children?
- When will the alleged perpetrator next have access to the victim?
- Is there an alternative placement/safety plan in place for the victim?
- Has the alleged perpetrator been substantiated and/or convicted of sexual abuse prior to this report that you are aware of?
- Has the alleged perpetrator intentionally exposed the child to sexually explicit material? If so, what kind of material?
- Has the alleged perpetrator taken pictures or videos of the child engaging in sexual activities or sexually explicit poses? If so, do you know WHEN this occurred, or WHERE it occurred and where the photos/videos would be now?
- Are you aware of any computers/cell phones in the possession of the alleged perpetrator that could contain child pornography?
- Are you aware of any incidents of inappropriate sexual behaviors involving the child?
- Do you know if the child's caregiver is protective in regard to ensuring the safety of the child and preventing further sexual abuse by another person?
- Has the child been evaluated by a medical professional? If so, who is the medical professional? Get a release to get medical records.
- Has the child been evaluated by a mental health professional? If so, who is the mental health professional to get release for records?

i) Alleged Perpetrator

- Coordinate with your law enforcement partner around the time, location, and strategy for interviewing the alleged perpetrator.
- Multiple research sources found that using a "non-threatening," "non-judgmental," and "empathetic" approach resulted in increased confessions.

j) Witness/Collateral Interviews

- Interview anyone that the ACV names as a possible witness

- Ask about any witnesses or collaterals who could identify changes in the child's behavior, corroborating details, history, or grooming behaviors.
- Obtain a statement from ACV's therapist, teacher, or extended family, if applicable.

k) Commercial Sexual Exploitation of a Minor (CSEM) questions for adults:

- Does the child have a history of having older boyfriends?
- Is the child ever alone or is he/she always accompanied by the boyfriend?
- Does the child have recent tattoos or brandings? Bar codes and gang tattoos are the most common.
- Does the child have items or receive services that are expensive or inappropriate for his/her age? (Expensive hair styles, manicures/pedicures, provocative clothes, expensive jewelry, purses, or clothing)
- Does the child have a history of frequent runaway?
- Have you noticed a change in the child's behavior and/or demeanor?
- If the child is a runaway, does the child hang around or spend time at truck stops, service stations, hotels, or motels?
- Is the child secretive and/or overly possessive of their cell phone?

4. Assessment of Safety and Risk

a) Assess for Safety Concerns:

- The perpetrators current access to the ACV and other children
- Co-occurring factors such as alcohol or substance abuse, mental health disorders, or domestic violence impacting the sexual abuse.
- The non-offending caregiver's response towards the allegation
  - Had the child previously disclosed the parent/caregiver already? If so, what was the reaction?
  - Do they have a plan for keeping the child safe?
  - Are they willing to take the child for a medical exam and forensic interview?

b) Assessing for Risk

- What has been the AP's access to the other children in the home? Have there been any signs of grooming behaviors? Has the AP had a history of grooming or sexually abusing other children in the past?
- Must complete a global assessment on the family to address their needs
  - If the AP has to leave the home, does it put the family financially at risk?
  - Is there a loss of support that the AP provided the family?
  - Is there a loss of support from other family members who don't believe the ACV?

5. Planning with the Family

   a) If the child victim lives in the home with the alleged perpetrator, the perpetrator should be asked to leave home during the investigation. It should be made clear that there is to be no contact with the alleged perpetrator during the investigation including but not limited to phone calls, text messages, social media, and facetime. (Refer to Policy *14.13, Non-Custodial Immediate Protection Agreements*).

   b) Protection includes following the steps in the immediate protection agreement, ensuring the child does not have contact with the alleged perpetrator, and not allowing the child to be put in situations where they will be around other non-protective adults. Support looks like telling the child you are there for them, comforting them, reminding them they are not in trouble, taking the child to therapy (if applicable), and cooperating with the tasks of the investigation.

   c) If a non-offending caregiver is unable to protect the child from the alleged perpetrator, a non-custodial expedited placement for the child should be identified for the duration of the investigation. Explain to the placement that the child should not be asked questions about the sexual abuse.

   d) Consider an order of protection.

   e) Consider conducting random home visits to ensure the perpetrator has not returned to the home.

6. Gathering and Documenting Evidence

   a) Develop an investigative timeline with all the points of evidence in the case including the following information below as well as any information gathered in interviews.

   b) Identifying Grooming Behaviors

      - In child sexual abuse cases, identification of grooming behaviors should be documented to support the classification decision. Identification of grooming behaviors can help corroborate a child's disclosure, witness statements, or physical evidence.
      - 7 Stages of Grooming (Center for Missing and Exploited Children)
        - Identifying and Targeting the Child
          - How did the offender find the victim OR how did the victim find the offender?
          - Get this information from multiple sources (child, perpetrator, non-offending caregiver, collaterals)
        - Gaining Trust and Access
          - How did the offender build trust with the family? How did the offender convince the caregivers to allow him or her to have access to the child?
        - Playing a Role in the Child's Life
          - What kinds of roles did the perpetrator play in the child's life?

- These behaviors give the child the impression that there is a loving and exclusive relationship between them and the offender
- The offender's strategy will adjust based on the child's age, needs, perceived vulnerabilities, and the type of child being targeted
- Ask if the offender shared secrets with the victim?
- Did the offender send the victim any gifts, money, a phone, etc.?
- When interviewing the offender, let them discuss how they played a large role in the victim's life and the influence they had

o Isolating the Child

- Once the "special relationship" is developed with the child, the offender will begin creating situations where he/she and the child can be alone
- The offender can cultivate a sense in the child that the child is loved or appreciated in a way that no other can provide
- Ask the victim in what ways the offender and him/her spent time alone
  - Where did they spend time alone?
  - How did they get to that spot?
  - How long did they stay there?
  - Did the sexual acts occur there?

o Creating Secrecy Around their Relationship

- How did the victim and offender privately communicate? (ex- social media, text messages, letters, etc.)
- Did the offender ever threaten suicide, disclosure, violence, or anything else if the victim tried to end the relationship or threated to tell about the relationship
- Ask the victim if anything she/he and the offender did together made him/her feel like they would get in trouble if they got caught?
- Precautions used by the offender (such as condoms or Plan B)
- Any evidence on non-sexual secrets

o Initiating Sexual Contact

- The offender will progressively sexualize the relationship through desensitization
- Does the victim or witnesses recall any "accidental touching", excessive tickling, wrestling, cuddling, etc.?
- Did the offender ask the victim to view certain websites, watch a show of movie with sexual content, or read a book that discusses sex in some way?

- Controlling the Relationship
    - The offender may use threats of guilt and enforce the secrecy to force the child's continued participation and silence
    - The offender may blame the child for allowing it to happen, normalize the sexual behavior, or threaten to end the emotional and material needs that the child has become accustomed to

7. Medical Exams
    a) When there is an allegation of sexual abuse and one (1) or more of the following are present, the CPS Case Manager must refer the child for a forensic medical evaluation. These circumstances include an ACV who:
        - Has pain or bleeding;
        - Has symptoms of a sexually transmitted infection (STI);
        - Is under the age of five (5) and there is an allegation of penetration;
        - Is delayed or has limited communication skills and there is an allegation of penetration; or
        - Is ten (10) or younger and there is a disclosure of penetration.
    b) When there is an allegation of sexual abuse and one (1) or more of the following are present, it is recommended that the CPS Case Manager consult with their supervisor to determine the need for a forensic medical evaluation:
        - Any child who is delayed or non-verbal;
        - Any child under five (5); or
        - Other special circumstances based on the investigator's judgement, at the request of the family, or if there is a conflict with any other recommendations or guidelines from a Child Advocacy Center, medical facility, or any other person or agency that provides forensic medical examinations.
8. If the sexual contact occurred in the past 72 hours, ensure the child receives the forensic medical exam immediately. Consult with your local leadership about where the child should receive the exam. The use of non-emergency forensic medical exams should be discussed with CPIT.
9. Obtain any past medical records that could pertain to the child's sexual abuse (including but not limited to genital infections or sexually transmitted diseases)
10. Photographs
    a) Does the home, room, location match the child's description leading to verification they were in that room? Photograph any items that corroborate the statements/disclosures
11. Documentation
    a) Document any correspondence establishing private communication between the child and alleged perpetrator including but not limited to text messages, messages on social

media, notes, and/or letters. Additionally, note if the child kept any diaries describing the abuse or had any written correspondence with family or friends disclosing the abuse.

b) Document possible past or current physical indicators of sexual abuse

- Pain or itching in the genital area
- Bruises or bleeding in external genitalia
- Venereal disease
- Nightmares or other sleep disturbances
- Frequent stomach illness with no identifiable reason
- Loss of appetite, or trouble eating or swallowing
- Frequent genital or urinary tract infections or irritations
- Torn, stained or bloody underclothing

c) Document possible past or current behavioral indicators of sexual abuse

- An increase in physical complaints
- Problems with bedtime or fear of going to sleep
- Fear of certain people or places (example: not wanting to be left alone with a babysitter
- Regression to infantile behaviors such as thumb-sucking or bed-wetting
- Abnormal interest in sex or knowledge of sexual matters inappropriate for the child's age
- Preoccupation with their body or masturbation
- Bedwetting — especially if it begins in a child who has been dry
- Sexual activities with toys or other children, such as simulating sex with dolls or asking other children/siblings to behave sexually
- Using new words for private body parts
- Refusing to talk about a 'secret' he/she has with an adult or older child
- Unexplained fear or dislike of certain people or places depression or withdrawal
- Changes in levels of confidence
- Sudden mood swings: rage, fear, anger, or withdrawal

d) Identifying Patterns

- Conduct a Sex Offender Background Check through the national registry.
- Obtain and document past criminal records of the alleged perpetrator.
- Review DCS history identifying past sexual abuse allegations or grooming behaviors:

- Was your perp a victim previously? What services were put in place to address this?
- Have there been allegations against your perp in the past?
- Has the ACV been sexually abused in the past? What was the parent/caregiver response?
- Was the parent/caregiver a victim in the past?

e) Services

- ♦ Alleged Child Victim
  - Consult with the CPIT team to ensure services are being offered through the Child Advocacy Center to address the sexual abuse
  - Ensure that any other identified needs are being addresses through appropriate services
- ♦ Other Family Members
  - Make services referrals to address the trauma to the non-offending caregiver and siblings, if needed
  - Implement services to address any loss of income or support experienced due to removal of the alleged perpetrator in the family's life, if needed
- ♦ Alleged Perpetrator
  - Offer services referrals for treatment for adults or youth who have sexually offended, are at-risk for sexually harming a child or adult or may be concerned about other sexual problematic behaviors.
  - Provide handouts and resources for addressing sexual thoughts and feelings towards children.

f) Internet Crimes Against Children

Online Grooming Techniques

- ♦ Step 1: Reaching out to the child and start grooming. Typically involving creating a fake account and poses as a child
- ♦ Step 2: Getting to know the child. Asking these questions to gain any piece of information that will allow them to secure the child's trust and align their responses with the child's
- ♦ Step 3: Sending private messages, usually about the family dichotomy and the child's personal life.
- ♦ Step 4: Initiate sexual conversations with suggestive and sexual questions
- ♦ Step 5: Requesting sexual images and/or videos.
- ♦ Step 6: Controlling the child through the possession of images or videos.

g) Problematic Sexual Behaviors in Youth

- Around 40-50% of sexual abuse occurs at the hands of other children or adolescents. The motivations behind problematic sexual behaviors in children are often unrelated to sexual gratification and are rooted in abuse or neglect.
- Refer to the DCS Children with Sexual Behaviors Chart to identify if the behaviors are normal, concerning, or problematic.
- Interviewing Children and Adolescents with Sexual Behavior Problems
  - If the child is 12 or under, schedule a forensic interview for the child
  - If the AP is a minor, we must get the AP's parent/guardian's permission before we interview them. Consult with law enforcement to discuss who will be leading this interview.
- Assess the minor AP for any history or current abuse. Assess for any possible service needs or support.

h) Engaging the Non-Offending Caregiver

- Provide empathy and support regarding the trauma they are experiencing.
- Educate caregivers regarding sexual behavior problems, sexual development in children, and treatment.
- Provide caregivers with protective strategies to ensure other children can be safe around their child.
- Educate parents on support resources available to them.

i) Assessing Safety and Risk

- Is the behavior harming others or having a harmful impact on others? This can be done through physical force, intimidation, threats, or humiliation.
- Is the behavior harming the child him/herself? This can be physically or emotionally.
- Has the behavior occurred before? What has the response been in the past?
- Who is the sexual behavior occurring with? What is the age and developmental difference?
- Where did the behavior occur?
- How often has the behavior occurred?
- What is the child's response to these behaviors occurring?
- Do the caregivers understand that the behavior is problematic?
- Can the caregivers provide the needed supervision?

j) Safety Planning

- If the child lives in the home with other children, ensure the children will be supervised by an adult when they are in the home together and the children will not be alone together in any parts of the home.

- Create a communication plan involving frequent check ins with the children to ensure there is no sexually inappropriate behavior.
- Monitor electronic devices and access to the Internet.
- Teach simple rules about boundaries and sexual behavior.
- Always communicate with other adults to provide and arrange for appropriate supervision when the child is with other youth.
    - Children who have had inappropriate sexual behaviors need line-of-sight supervision when interacting with other children.
    - Children who have broken personal boundary rules should not bathe or sleep with other children or have unsupervised time with younger children.

k) Services

- Consult with the Child Advocacy Center and/or regional psychologist to arrange for appropriate services related to the sexual behavior problems.
- Effective treatment should address the child within the context of family relationships and should involve the children's caregivers.

l) Classifications and Case Closure

- Children with Sexual Behavior Problems separates children (12 or younger) from adolescents who have engaged in sexually abusive behavior. This also applies to youth who are over the age of 13 but developmental function as a 12-year-old child or younger at the time of the incident. This term is used because it describes the behavior rather than labeling the child as an abuser.
- Minor Perpetrators
    - The Standard of Evidence is the same for adult perpetrators and minor perpetrators – we must have a preponderance of evidence in order to substantiate.
    - When considering substantiation, we must account for normal childhood behavior and if the minor has any intellectual or developmental disabilities.
    - All minor perpetrators who are substantiated automatically get a Formal File Review.
    - The 'In Care Of' field must be completed in the Electronic Record System for every minor perpetrator.

m) Validation criteria specific to child sexual abuse

- The ACV's statement that the abuse or neglect occurred. The following elements are typical in situations of sexual abuse, and shall be considered in assessing the weight to be given to the ACV's statement:
    - History of relationship

- Identified grooming behaviors and history.
- Progression of physical touching, from activities that appear acceptable at first, but over time become sexual in nature (typically referred to as grooming).
- Multiple incidents occurring over a period of time with the same ACV and AP, however a one-time instance could be sufficient for substantiation.
- Details of Abuse
- Explicit knowledge of sexual activity. The ACV relates explicit details of the sexual experience. This is especially relevant where the details are beyond the knowledge typical of a child of the victim's age or developmental capacity.
- Specific details of the incident(s), such as a location and/or time. If a specific location/date is not given, the ACV is able to provide other details of the environment. Expected detail should correspond with the child's age and developmental abilities.
- Consistency in the ACV's story. If the child is interviewed more than once, the responses and statements are generally consistent from one interview to the next. When statements do not align, the investigator needs to look at other pieces of evidence for corroboration.
- Parts of the story are corroborated by other circumstances and/or witnesses.
- The ACV indicates that he/she was instructed, asked, and/or threatened to keep the abuse secret.
- Elements of coercion, persuasion, or threats to get the ACV to engage in the activity are evident.

♦ The classification decision will be presented at CPIT for discussion prior to closure.

- If law enforcement has not completed their investigation or perpetrator interview, we may still close our case if:
- All DCS investigative tasks are completed;
- Service referrals have been made;
- We have reached our preponderance of evidence (i.e. without the AP's statement).

n) Letter A

♦ The Notification to Substantiated Perpetrators (Letter A) can be held at the request of the case manager and/or supervisor, if sending the letter could hinder law enforcement's continuing investigation.

♦ The letter must be sent once the law enforcement investigation is completed. The CPS Case Manager will notify the Admin Assistant in the region who sends the letters.

o) Prevention Strategies

- Children who are sexually abused are at an increased risk of revictimization. Because of this, we must engage non-offending caregivers around the importance of being educated on prevention strategies.
- Child centered prevention strategies for parents/caregivers
  - Ask the child to identify the safe adults in their lives
  - Body safety rules for children
    - We use the correct names for body parts.
    - No one is forced to hug, kiss, or be touched- we are the bosses of our own bodies!
    - We don't look, touch, or play games with other people's privates.
    - When someone says 'no' or 'stop' – we listen.
    - No one should ask us to keep a secret, even a small one.
    - It is always right and never too late to tell if someone breaks a body safety rule.
  - Practice body safety check-ins with children. After sleepovers with friends, weekends with extended family, playing at the neighbor's house, etc.
  - Share with other adults and children the rules of body safety that exist in your family
  - Reduce one-on-one activities with adults and other children as much as possible
  - Ensure that activities are observable and interruptible
  - Encourage open communication with your children and start conversations with them about what to do in certain scenarios.

p) Conducting Investigations on the Commercial Sexual Exploitation of a Minor

- Notifications
  - When an investigation includes Commercial Sexual Exploitation of a Minor (CSEM), the following notifications are made:
    - CPS Case Manager notifies the CPS supervisor immediately per DCS Policy *14.6, Child Protective Services Case Tasks and Responsibilities*.
    - The CPS Case Manager notifies the Child Protective Investigative Team (CPIT) partners per DCS Policy *14.7, Multi-Disciplinary Team: Child Protection Investigation Team* when a case is received alleging child sexual abuse with a CSEM component.
    - The CPS Case Manager notifies the Tennessee Bureau of Investigation (TBI) Tennessee Human Trafficking Hotline (855-55-TNHTH) within twenty-four (24) hours or immediately if deemed necessary by the CPS supervisor per DCS Policy *14.6, Child Protective Services Case Tasks and Responsibilities*.

- The CPS Case Manager notifies a local non-government organization that specializes in commercial sexual exploitation within twenty-four (24) hours or immediately if deemed necessary by the CPS supervisor per DCS Policy *14.6, Child Protective Services Case Tasks and Responsibilities*.
- Per federal mandate, the CPS Case Manager notifies the Office of Tracking in Persons by emailing ChildTrafficking@acf.hhs.gov or calling 202-205-4582 within twenty-four (24) hours after discovering a foreign national child under the age of 18 who may be a victim of sex-trafficking to facilitate the provision of assistance. To the extent possible, the Case Manager should provide the child's name, age, location, and county of origin; location of exploitation and suspected form of trafficking along with point of contact information for the Case Manager or supervisor.

q) Convening the Child Protection Investigative Team

- When convening CPIT, the CPS Case Manager discusses and determines the method of investigation in collaboration with the CPIT partners. The following decisions are made:
  - In consultation with the CPIT partners, it is determined if local law enforcement or the TBI is the lead law enforcement agency during the investigation.
  - In consultation with the District Attorney's (DA) office and the Child Advocacy Center (CAC), the method (minimal facts, forensic interview, extended forensic interview) and timing of interviewing the alleged child victim (ACV) is determined, including who is conducting the interview, This determination takes into consideration:
    - The immediate need to assess the safety and risk of the ACV to determine proper placement;
    - Gathering evidence in a legally defensible manner; and
    - The capacity of the ACV to provide information.
  - To ensure the physical health and provide information for the care of the ACV, the CPS Case Manager consults with a medical provider on the timing of a medical evaluation or forensic medical evaluation to include potential reduction of sexually transmitted infections and/or other health needs. Barring good cause, the CPS Case Manager refers the ACV for a forensic medical evaluation immediately and no less than seventy-two (72) hours if:
    - A sexual act occurred within the last twenty-four (24) hours;
    - Any child/youth who has been on a runaway episode more than 24 hours; and/or
    - Any child/youth who reports sexual assault, physical assault, and/or intravenous drug use.

      Note: The child/youth may choose to refuse a medical evaluation but should

be taken to a health care provider regardless so the child/youth may discuss the decision with a medical professional. See Protocol for Medical Evaluations for Runaways or Commercial Sexual Exploitation of Minor (CSEM) and Protocol for Health Services for Trafficked Youth.

r) The CPS Case Manager documents all evidence collected from the interview(s) and the forensic medical evaluation in the Electronic Record System.

s) The CPS Case Manager consults with their supervisor throughout the investigative process to evaluate appropriate action steps.

Note: Review Safety Notice: Creating Safe Environments for Youth Survivors of Exploitation, for additional information

t) Investigative Tasks for all cases of Commercial Sexual Exploitation of Minors

- CPS Case Manager collects information about the ACV including:
  - Age;
  - History and risk of running away;
  - Length of time sexually exploited;
  - History of involvement with juvenile court or law enforcement;
  - Use of social media for sexual exploitation;
  - Receptiveness, cooperation, and perception of the sexual exploitation;
  - Mode of entry to sexual exploitation;
  - Type of sexual exploitation endured
  - Sexual orientation;
  - History and presence of alcohol and/or drug abuse;
  - History of trauma endured including the threat, force, or fear imposed by the alleged perpetrator (AP);
  - Use of terminology that indicates sexual exploitation.

    Note: It may not be possible or in the child's best interest to collect all the above information during the initial interview or directly from the child as it may increase the trauma to the child. Use of collaterals, witnesses and other evidentiary sources should be explored in a trauma informed, survivor centered model.

- Collaborates with the lead law enforcement agency on the investigation to determine if any Amber Alerts, Missing Persons, Absconder or Runaway Reports have been made in relation to the ACV.
- Request a National Crime Information Center (NCIC) records check regarding the ACV to determine if the ACV may be under the supervision of another state's jurisdiction. The check may also obtain additional information regarding safety

concerns that may affect placement decisions of the ACV.

- Completes the CSEM component of the FAST.

u) Investigative Tasks for Non-Custodial Cases

- When conducting an investigation in the home, the home environment is assessed in which the ACV resides or may be returning when the ACV is suspected of or has been previously trafficked. The home assessment includes the identification of:
  - Any abuse or neglect issues, including those that:
    - Facilitated the ACV's decision to leave the home, if applicable;
    - Allowed for access by an AP;
    - Indicated active or passive participation in the CSEM by the parent/caretaker
  - The ability of the parent/caretaker to care for the ACV; and
  - The ability of the parent/caretaker to appropriately prevent the ACV from running away.

    Note: Also Refer to Safety Notice: Creating a Safe Environment for Youth Survivors of Exploitation.
- If the home is not determined to be safe for the ACV, then alternatives may be considered under DCS Policies *14.13, Non-Custodial Immediate Protection Agreements* and *14.14, Removal: Safety and Permanency Considerations* up to and including removal of the child into state custody.

v) Investigative Tasks for Custodial Cases

- Placement considerations include the following:
  - Safety concerns including the:
    - Risk of running away;
    - Potential recruitment of other children;
    - Access to the ACV by the AP;
    - Safety of those in the foster home;
    - Availability of foster placements and closeness of multiple ACVs; and
    - Transportation needs
  - Knowledge and experience of caring for a victim of CSEM.
  - Treatment needs.

w) Services

- The CPS Case Manager invites the following parties to participate in the Child and Family Team Meeting (CFTM):
  - CANS Consultant

- DCS Psychologist
- Non-Governmental organization representative; and
- Victim Witness Coordinator (DA, CAC)

♦ When building a service plan, the CPS Case Manager works with the non-governmental organization in their area of expertise in assisting minors involved in trafficking as early in the case as possible.
  - The goal of this collaboration is to:
    - Build rapport with the ACV;
    - Reduce trauma to the ACV;
    - Identify the services that meet the specific needs of each ACV; and
    - Facilitate effective delivery of these services

♦ Consideration must be given to the:
  - Availability of services;
  - Proximity to the ACV; and
  - Transportation to and from appointments

♦ When an ACV is in a secure facility (i.e., an ACV involved with the Office of Juvenile Justice) the CPS Case Manager coordinates with the assigned Juvenile Justice or Family Service Case Manager to incorporate any additional services. This coordination must include the need to initiate services while the ACV is in a secure facility by utilizing secure transportation to the provider or asking a provider to offer service in the facility.

Sexual Harassment

1. *Protocol for CPS Categories and Definitions of Abuse/Neglect* definition:

   a) Unwelcomed sexual advances, requests for sexual favors, or verbal comments, gestures, or actions of a derogatory or offensive sexual nature by one detainee or resident directed toward another; and

   b) Verbal comments or gestures of a sexual nature to a detainee or resident by a staff member, contractor, or volunteer, including demeaning references to gender, sexually suggestive or derogatory comments about body or clothing, or obscene language or gestures.

   Note: For the purposes of a child in the custody of DCS placed at a residential facility, a "person living in the child's home" includes a person living in a residential setting with the child.

   Note: Sexual harassment within congregate care facilities where youth are placed.

   c) Case Considerations

- Sexual Harassment is underreported and may be more pervasive than studies suggest.
- Contributing factors to underreporting include fear of retaliation from staff, lack of trust, stigma, etc.
- Surveillance does not prevent harassment. Over 60% of incidents occur in areas with active security cameras.
- Male youth report significantly more harassment by female staff, particularly involving verbal or non-contact forms.
- LGBTQ youth make up 12% of the juvenile population but account for 40% of those reporting victimization, including harassment.
- In FY24, Wilder Youth Development Center had a total of 12 PREA investigations, 6 of which were Sexual Harassment Allegations.

d) Engagement and Interviewing

- Understand the case. Review any prior reports and relevant history.
- Know your legal obligations. Be clear on mandated reporting laws and confidentiality limits.
- Secure a quiet, private, non-threatening space free from distractions and authority figures.
- When speaking with the child, acknowledge this is a difficult conversation. Avoid any statements that would blame the child. Be aware of your own reactions, maintain a calm demeanor.
- Avoid promises. Never promise confidentiality or outcomes you can't guarantee.
- Record the details of the conversation as soon as possible, including what the youth shared, their emotional state, and any other relevant observations.
- Ensure accuracy and avoid interpreting or making assumptions about the child's words.

e) Interviewing parents/caregivers

- Provide time and space for them to discuss their feelings, including any denial or disbelief, their own trauma, and possible manipulation by the offender.
- Provide the non-offending caregiver with information on recognizing trauma in their child, and some methods they can use to address it.
- Provide information to non-offending caregivers around the facts about child sexual abuse.
- Explain the importance of supporting the child.
- Ask how the siblings and extended family members may respond to the allegations.
- Discuss strategies for long term prevention and safety.

- Evaluate their ability to protect the child in terms of financial resources, mental stability, and informal/formal support systems.

f) Interviewing Collaterals

- When interviewing staff about a sexual harassment allegation, the goal is to gather facts, assess their conduct and knowledge and determine if policies were followed.
- Questions should be non-accusatory, and tailored to whether the staff is a witness, potential perpetrator, or supervisory figure.
- Interview anyone that the ACV names as a possible witness.
- Ask about any witnesses or collaterals who could identify changes in the child's behavior, corroborating details, history, or grooming behaviors.
- Obtain a statement from ACV's therapist, teacher, or case manager, if applicable.

g) Questions to ask Collaterals

- Can you describe your role in this facility and your usual responsibilities?
- What training have you received on sexual harassment and PREA?
- What is your understanding of the facilities policy on youth sexual harassment?
- Where were you when the incident was reported or occurred?
- Who else was present?
- Can you tell me about your interactions with [youth's name]?
- Have you seen or heard anything that made you or someone else feel uncomfortable?
- Can you tell me what you saw or heard between [person A] and [person B]?

h) Assessment of Safety and Risk

- Separate the involved parties, removing the alleged perpetrator from contact with the victim and witnesses.
- Ensure the alleged victim is assessed by medical and behavioral health professionals, if applicable.
- Check video footage of the time and location of the incident.
- Evaluate blind spots, poorly lit areas, or under-supervised zones.
- Assess whether staff were actively supervising and following protocol.
- Were PREA staffing ratios met?
- Review staffing logs.
- Obtain Safe Housing Assessment and Safe Housing Re-Assessment forms.
- Always complete a global assessment for any concerns unrelated to initial referral.
- Have there been prior concerns about specific staff failing to monitor?

- The investigative report must show an effort to determine whether staff actions or failures to act contributed to the abuse (PREA Standard 115.371(g)(1).

i) Planning with the Family

- Advise family of investigation outcome.
- Convene child and family team including the youth, care giver, facility representative, case manager or probation officer, mental health professional.
- Ensure appropriate services for the child are referred for when returning home.
- Equip the caregiver to watch for signs of trauma, fear of retaliation, regression or behavioral issues.
- Education planning.
- Screen the home for risk factors and ensure it is safe, stable, and free of prior abuse.

Psychological Harm

2. *Protocol for CPS Categories and Definitions of Abuse/Neglect* Definition:

a) A repeated pattern of caregiver behavior or extreme incident(s) that convey to children that they are worthless, flawed, unloved, unwanted, endangered or only of value in meeting another's needs and may include both abusive acts against a child and failure to act; neglectful behavior when age appropriate action is required for a child's healthy development (e.g., when a child is shown no affection). It can occur as part of an extreme one-time incident, e.g. a parent frustrated about continual bed- wetting forces a six (6) year old to wear diapers in the neighborhood) but is usually chronic.

Note: An allegation of psychological harm does not have to come from a professional.

b) Some types of psychological harm might include:

- An injury to a child by a caregiver that impairs his/her intellectual, emotional or psychological development.
- Verbal and non-verbal caregiver acts that reject and degrade a child such as belittling, degrading, shaming and ridiculing.
- Terrorizing; including caregiver behavior that threatens or is likely to physically hurt, kill, abandon or place the child or child's siblings, toys, or objects in recognizable dangerous situations to terrorize the child.
- Isolating that includes caregiver behaviors that consistently deny the child opportunities to meet needs for interacting or communicating with peers or adults inside or outside the home. Confining the child or placing unreasonable limitations on the child's freedom of movement within his or her environment.

3. Case Considerations

a) Seek and document the opinion of a licensed mental health professional (DCS Psychologist or community provider)

b) This allegation may be classified as Substantiated with a licensed mental health professional's opinion that psychological harm to the child did occur.

4. Engagement and Interviewing

a) Interviewing the Child

- Explore with the child their daily habits, including eating habits, interactions with friends/peers, family members and other adults
- Explore activities the child enjoys
- Explore what makes the child happy, sad, angry, etc.
- Explore who the child spends time with, or likes/dislikes to spend time with
- Explore with the child to see if the child has talked with other family members or friends about home life
- Explore the type of discipline used in the home, who enforces discipline, do the other children in the home get disciplined, how are other children in the home disciplined?
- Tell me about your relationship with your parents/caregiver.
- When there is a conflict in your home, what does that look like?
- In what ways does your parent belittle, degrade, shame, or ridicule you?
- Are you able to interact with peers or adults within your environment?
- Do your parent/caregiver's behaviors ever make you fearful or feel unsafe?
- Tell me about the incident and how it made you feel.
- Has anyone else witnessed this behavior? If so, who?

b) Interviewing parents/caregivers

- Initiate typical investigative questions to develop an understanding of safety and risk factors, specifically including mental health issues (symptoms, diagnoses, medications), physical condition of the child, financial situation (income, public assistance, other community resources), and discipline practices.
- Assess the parent/caregiver's protective capacity.
- Avoid any blaming questions or accusations.
- Explore the child's current mental health, specifically if the child has been seen by a psychiatrist or therapist recently, when was the date of the child's last therapy session, is there a current diagnosis, has the child been seen by a pediatrician, Has the child's been seen by a primary care physician, is the child prescribed any medication, does the child have any allergies or medical diagnoses?
- Explore the child's daily habits, including who the child spends time with, friend groups, relationships with family members, teachers, other adults; changes in recent behaviors or physical appearance.

- Explore external connections for adults and child (e.g. Church, groups, school activities, etc.)
- Explore whether the child is meeting developmental milestones.

c) Interviewing collaterals

- Interview all other persons who may have witnessed the psychological harm or have relevant information regarding the circumstances of the ACV and family, including referents, other adults in the home or community, school personnel, professionals, or staff of other agencies.
- Questions to ask collaterals:
  - How did you learn of the psychological harm?
  - When was the last time you saw the child?
  - What leads you to believe that the child is being psychologically harmed?
  - Has the child asked neighbors or others for help or expressed fear or concerns about home life?
  - What is the child's current mental or physical condition?
  - When was the last time you were in the home?
  - Did you observe any aggressive, harsh or demeaning language toward the child?
  - Did you observe any physical aggression toward the child, including any marks or bruises on the child?
  - Are you aware of the family's structure and support system?
  - Are you aware of the family's income or participation in public assistance, or the family's access to community resources?

5. Assessment of Safety and Risk

a) Current Safety Concerns

- Explore factors such as parent/caregiver alcohol or substance abuse, or untreated mental health disorders, including depression.
- What is the child's current mental health condition? Does the child need immediate mental health assessment?
- Does the child have any developmental or intellectual disabilities?

b) Risk and Protective Factors

- Is the child in school/daycare or otherwise visible in the community?
- What is the utilization of family and community supports? Are there caring adults outside the home who can serve as role models or mentors for parents/child?
- What is the parent/caregiver's level of understanding of children's needs, child development, and parenting skills?

- Do the parents/caregivers accept responsibility for the behavior?
- Explore parental characteristics such as young age, low education, single parenthood, large number of dependent children, and low income.
- Explore parental thoughts and emotions that tend to support or justify maltreatment behaviors.
- Explore family stressors such as: separation or divorce, and violence, including intimate partner violence, poor parent-child relationships, child behavioral issues and other negative interactions.

6. Planning with the Family
   a) If immediate harm factors are present, as determined by formal and informal assessments, a safety intervention must be considered.
   b) Involve the non-offending caregiver in the safety planning process.
   c) Engage the medical and mental health professionals to assist in the safety planning process. Will the child be hospitalized? For how long? Will there be any special care or diet required upon discharge?
   d) All efforts to reduce risk and safely keep children at home with the parent/caregiver should be made. Situations that may rise to the level of out-of-home placement include:
      - All safety planning options have been explored but are not available for various reasons.
      - The parent/caregiver is unable or unwilling to accept services.
      - The parent/caregiver is unable or unwilling to make changes for the child's health and safety.

Domestic Violence

1. *Protocol for CPS Categories and Definitions of Abuse/Neglect* Definition:
   a) Acts of violence, coercion, or intimidation against a parent or caregiver by an intimate partner that could cause injury to a child, create an environment of hostility or instability, and/or impact the caregiver(s) ability to provide for the basic needs of the child(ren) including food and supervision.
      - Domestic violence includes, but is not limited to:
      - Physical violence such as hitting, shoving, spitting, destroying possessions, threats toward any member of the household, throwing things, and attacks.
      - Any form of domestic violence (to include but not limited to emotional abuse, financial control, stalking, harassment, violence towards pets, or sexual assault) where the safety and/or wellbeing of the child is impacted.
      - Incidents leading to the arrest of the caregiver for domestic violence.

2. Case Considerations

    a) When a family has domestic violence concerns, unique factors must be taken into consideration during the course of the CPS case:

    b) Exposure to domestic violence causes damage to children, even when children are not physically or sexually harmed.

    c) Domestic violence is a parenting choice made by the perpetrator.

    d) Partnering with the non-offending caregiver is crucial for the wellbeing of the children.

    e) Identifying and assessing domestic violence and its impact is critical in reducing risk and potential trauma experienced by children.

    f) When domestic violence has occurred, perpetrators should be held solely responsible for that violence, while receiving interventions that address their abusive behaviors. Accountability must be consistent through systems (LE, DCS, Courts, domestic violence programs, Batterer's Intervention Programs).

3. Engagement and Interviewing

    a) Separate interviews are critical. Interviews with children and non-offending caregivers should be conducted when the alleged perpetrator is not present or in the vicinity. If upon an initial home visit both the alleged perpetrator and non-offending caregiver or child are present, collect some basic family information and then inform the family that you will schedule separate interviews later, stating this is a routine requirement.

    b) Engaging the Non-Offending Caregiver

        - Let the non-offending caregiver offer suggestions for where and when to meet and when it would be safe. Make a plan in case the alleged perpetrator shows up.
        - Explain the CPS process and that child safety is the goal of the assessment.
        - Build trust and rapport:
            - Even if the non-offending parent is accepting responsibility, explain that the DV is not their fault;
            - Empathize the love and attachment they may have for the alleged perpetrator;
            - Express concern for the non-offending caregiver and children's safety;
            - Be non-judgmental and non-threatening.
        - Questions to ask the non-offending caregiver:
            - Initiate conversation with questions about the children such as favorite school topic or activity.
            - Move into a neutral inquiry about the non-offending caregiver's relationship with their partner:
                - "Tell me what you like most about your partner"
                - "All couples have disagreements. How do you and your partner handle

them?"

- Explore the incident that prompted the referral
  - Ask for details about where, when, and how it occurred.
  - "How did your children respond to this incident at the time and afterwards?"
  - "Where were they at the time of the incident?"
- Explore the alleged perpetrator's relationship with the children
  - "All couples experience conflict about children at times. Related to the children, what sorts of things do you argue or disagree about?"
  - "Do you have any concerns about your partner's behavior with the children when you are not around?"
  - "Does your partner support the way you have handled the children?"
- Questions to help identify Risks and Impact on the Children
  - "Have your children ever seen or heard your partner act violent or abusive towards you? Have they ever seen the aftermath of the violence and abuse?"
  - "Has your partner's behavior ever made you feel afraid for the safety of your children? In what ways?"
  - "Have the kids ever been hurt, either on purpose or accidentally, as a result of your partner's behavior? How do the kids react during these incidents?"
  - "Has your partner ever used or threatened to use the children in any way to control or hurt you?"
  - "Has your partner ever interfered with your efforts to care for the children, like making it difficult for you to take them to the doctor?"
  - "Are the children displaying any problems or difficulties that you think are related to their exposure to your partner's violent or abusive behavior? "
  - Ask what strategies the non-offending caregiver has already been using to keep themselves and the children safe
  - "What have you tried in the past to keep yourself and the children safe that felt helpful? What have you tried that did not feel helpful?"
  - "Have you told anyone about the abuse? What happened?"
  - "Have you ever left home because of the abuse? Where did you go and what happened?"
  - "Have you ever called the police or 911 or filed a restraining order or criminal charges? What was your partner's response? Did you find this helpful? Why or why not?"
  - "Have you ever used a domestic violence shelter or services? Was it helpful? Why or why not?"

- "Can you describe what you do on a daily basis to parent the children and how you meet their needs despite what has happened? "

- Assess and address non-offending caregiver's desire and/or barriers to leaving.
  - How do their cultural and religious beliefs guide them in their decision making around their relationship?
  - Have they have ever considered leaving in the past. If they have, ask them what were the barriers that made them stay?
  - Ask questions to better understand the survivor's story, the context of her/his circumstances and decisions, and the survivor's hopes are the relationship with the perpetrator
- Discuss safe alternatives/resources that the non-offending caregiver can access.
  - "What would be helpful to you and the children?"
  - "If your partner were to become violent today, what options do you have?"
  - "Do you have friends, families, or others you can depend on to help you and your children stay safe?"
  - "If you left, would your partner try to force you to come back or try to get the kids from you?"
  - "What can DCS do to help you feel safer?"

c) Engaging the Alleged Perpetrator

- Engagement with alleged perpetrators as parents is important because:
  - Demonstrates that they are just as responsible for the children as the non-offending parent;
  - Allows the Case Manager to understand the relationships between the offending parent and their children;
  - Helps the Case Manager identify the parenting style and how to support the alleged perpetrator's parenting needs;
  - Keeps the focus of the case on the children and their needs;
  - Helps determine the level of risk the offending parent poses to their children.
- Prior to speaking to the alleged perpetrator, speak to the non-offending caregiver and children to assess for dangerousness to the family and yourself as the case manager. For safety precautions, consider interviewing the alleged perpetrator in the office or with a supervisor.
- Building rapport with the alleged perpetrator through a neutral and nonconfrontational manner is a crucial first step. Start the interview with asking general questions about parenting duties or the children.
- Maintain structure to the interview and come prepared with the flow and questions

that need to be asked. Clearly communicate the goals and format of the interview to convey control and authority over the process.

- Explore the incident that prompted the referral. Do not provide information about the domestic violence reported by the non-offending caregiver as this may compromise safety. Instead, focus on third party reports such as law enforcement records, civil protection orders, hospital records, or prior CPS documentation.
  - "Tell me about the reported incident."
  - Ask for the details about where, when, and how it occurred.
  - Try to get specific details about the violence and ask questions about that elicit information about how the partner or ex-partner acted, e.g. what did he say?, what did he do?
  - "How did the children respond to this incident as it was occurring?"
  - "How did the child respond afterwards?"
  - Did the child experience anything as a result, such as observing bruises, separation from family, incarceration of one of the parents, etc.
- Explore with AP their thoughts on their relationship with the family:
  - "How long have you been in relationship?"
  - "How much time do you spend with your children?"
  - "What kind of activities do you do with the children?"
  - "All couples experience conflict about children at times. Related to the children, what type of things do you argue or disagree about?"
  - "Who makes the final decision on issues relating to the children?"
  - "What role do you play in the disciplining of the children?"
  - "How do you respond when the children are disobedient to the rules in the house?"
  - "How do you react when you disagree with your partner?"
  - "Would you describe yourself as being jealous or having a temper?"
  - "Who in the relationship controls or makes decisions about parenting, spending money, spending time with friends, etc.?"
  - "Who has more access to financial resources?"
- Explore with AP their understanding of the impact of the domestic violence:
  - "What do you believe is the most negative consequence of this behavior?"
  - "How do you think that behavior impacts your partner?"
  - "How do you think that behavior impacts the children?"
  - "How does this behavior impact you?"

- Focus on obtaining information about behaviors and the level of responsibility the perpetrator accepts responsibility for. Document the responses. Avoid arguing or debating. Focus on active listening and avoiding judgement.
- Explore with AP attempts to end the abuse:
    - "Will you take steps to get rid of weapons/get into substance abuse treatment/engage in domestic violence counseling?"
    - "Are you willing to move out? Do you have someone you can stay with?"
    - "If you move out or your partner leaves, will you be able to stay away for a period of time?"
    - "If you move out, what are you willing to do to continue to support your children financially?"
    - "What else are you willing to do to create a safe and healthy environment for your children?"
    - "What are your hopes with regard to this relationship?"
    - "Can you identify when you might become violent? Do you know your warning signs?"
    - "What has helped you avoid violence in the past? Are those things still available to you today?"
    - "Have you ever been involved with the police or the court? Are you currently on probation, parole or have an open case with the court system?"
    - "Have you ever been referred to anger management or domestic violence counseling?"
    - "Would you be open to some services?"
    - Focus on understanding the perpetrator's state of mind as this may be crucial in the safety planning process.

d) Engaging the Child

- Recognize that children may be observing the domestic violence but interpreting it in different ways.
- Be careful not to demonize the alleged perpetrator when speaking to the non-offending caregiver or the children as they have varying and complicated relationships with them and you may lose buy in/engagement with the family.
- Partner with the non-offending caregiver by asking how best to approach the children as they may understand the children's response
- Be aware that children frequently receive direct and indirect messages that the domestic violence is a family secret
- Use age and developmentally appropriate questions

- Utilize a domestic violence assessment with the child
- Opener: “Sometimes when moms and dads are angry, they may yell at each other or even hit each other. I know fights can be scary. I want to ask you a few questions about your parents fight and what you think about it. Would that be, ok?”
    - Explore Child’s awareness of behavior
    - “Do you like spending time with your dad?”
    - “Do your mom and dad get along most of the time?”
    - What happens when your dad is angry?”
    - “When your parents are fighting, does anybody ever get hurt or hit?”
    - “Have the police ever been called to your house? Have you ever had to leave your home because of people fighting?”
    - “What do you do when your parents are fighting?”
    - “Have you ever felt afraid when there is fighting in the house? What frightens you the most when they are fighting?
- If the child is aware of the domestic violence:
    - “Tell me about the fight that happened last night between your parents. “
    - Ask for details about where, when, and how it occurred.
    - Assess for responses to the incident
    - “What did you do?” “How did you feel?“
    - Explore the reaction to items like injuries to parent, separation from family, incarceration of partner, etc.
- Explore risks to child posed by the domestic violence
    - “Have you ever been hit or hurt when your mom and dad are fighting?”
    - “Has your brother or sister ever been hit or hurt during a fight?”
    - “What do you do when they start arguing or when someone starts hitting? “
    - “Has anyone ever threatened to hurt your pet?”
- Explore the impact of domestic violence exposure to the child
    - “Do you think about your mom and dad fighting a lot?”
    - “How does the fighting make you feel?”
    - “Do you ever have trouble sleeping at night?”
    - “Why do you think they fight so much?”
    - “What would you like them to do to make it better?”
    - What happens when adults argue/disagree?

- Does anyone throw things or damage property?
- Has anyone used a weapon?
- Do you know where the weapon is?
- Does anyone hit, shove, push?
- When was the last big fight?
- Have you seen injuries or damage to property after a fight?
- How does you mom/dad act after a fight?
- Have the police ever come when there is a fight?
- What do you and your siblings do during a fight?
- Have you or your siblings been hurt during a fight?
- Are you ever afraid during a fight?
- How do you feel during a fight?
- How do you feel after a fight?
- Do you talk to anyone after the fight?
- Are you worried about anyone during/after a fight?
- Do you feel safe at home?
- Where do you/siblings go during a fight?
- Have you/siblings ever tried to stop a fight?
- Have you ever had to take sides during/after a fight?
- Who would you call in an emergency?
- Have you ever called the police or 911 for help?
- Has anyone needed to go to the doctor after a fight?

♦ Explore protective factors with the child

- "What do you do when your mom and dad are fighting? "
- Such as stayed in the room, left the room or hidden, gotten help, tried to stop fighting
- "Have you ever called the police when your parents are fighting?"
- "Have you ever talked to anyone about your parents' fighting? "
- "Is there an adult you can talk to about what's happening at home? "
- "Have you talked with your mom about how you feel? Does it help you feel better? "
- "Can you tell me about things that make you happy about your family?"

e) Engaging a Family in a Shelter

- When a family or family member is residing in a domestic violence shelter, work with the family and the local shelter to coordinate appropriate visit times and meeting locations. When possible, the Case Manager should also coordinate case work and service planning with the shelter.
- Engage the school system in supporting transportation for children who are in school and living in the domestic violence shelter. Transportation services can be provided through the McKinney Vento Federal law (*https://www.tn.gov/education/finance-and-monitoring/elementary-and-secondary-education-act-esea/essa-title-ix.html*)
- Interviewing Witnesses
  - Tell me what you know about the incident.
  - Does anyone have any marks/bruises?
  - Have you obtained or do you need medical attention?
  - Is there a history of domestic violence in the home?
  - When was the last incident of domestic violence?
  - Has law enforcement ever been called regarding domestic violence?
  - Has law enforcement responded to the home regarding domestic violence?
  - Has anyone been arrested related to domestic violence?
  - What were the charges?
  - Were they held in jail?
  - Is there or has there ever been an order of protection?
  - When will the aggressor return to the home?
  - Are they protective of the children?
  - Will either party be willing to leave the home with the children?
  - Is there a visitation plan in place between the parents and the children?
  - Do the AP/victim live in the same home?
  - Has the child ever tried to intervene in DV incidents?
  - Have the children shown signs of emotional distress due to DV incidents?

4. Assessment of Safety and Risk

a) Assess for these Current or Historical Safety Concerns:

- The perpetrators current access to the non-offending caregiver and children;
- The child's harm or exposure to danger during the domestic violence incident(s);
- The perpetrator's coercive control diminishing the non-offending caregiver's

protective capacity;

- The pattern of abuse which puts the child and non-offending caregiver in danger;
- Any indication of the alleged perpetrator's obsessiveness, jealousy, depression, desperation, threats, use of weapons, or thoughts of suicide;
- Co-occurring factors such as alcohol or substance abuse, untreated mental health disorders, or brain damage;
- The non-offending caregiver's use of force or emotional abuse towards the child or perpetrator;
- Child's participation in violence or violent acts;
- Situational factors that could increase safety concerns;

b) Assess for Indicators of Level of Danger:

- The non-offending caregiver's instinct may serve as the most important indicator. Non-offending caregivers and children are in the most danger when they attempt to leave the relationship.
- The level of dangerousness appears to intensify over time.
- The Danger Assessment can be used when gathering information from non-offending caregivers about potential perpetrators. Please note that non-offending caregivers may not feel comfortable disclosing to child welfare and may be more honest with DV advocates.

c) Identifying Patterns

- Behavioral patterns are important to identify because alleged perpetrators don't act in isolated tactics. Always assess for the complete history, not just what is most recent.
- Criminal records and history of 911 calls should be collected, however, a lack of criminal record does not indicate an absence of DV in the home and should only be used as an indicator. Also note that nonoffending caregivers may have arrest records as well due to dual arrests in DV situations.
- Observe the family interactions to look for behaviors indicative of DV dynamics.
- Gather information from other sources to identify patterns of behavior.

d) Assessing Non-offending Caregivers as Parents

- When assessing non-offending caregivers, look at their capability to parent despite the DV including:
  - Consistent and appropriate discipline and parenting;
  - Providing stability and affection;
  - Meeting the emotional and developmental needs of their children.

e) Risk and Protective Factors

- Nature, extent, and patterns of domestic violence;
- Effects of domestic violence on non-offending caregiver and child;
- Help-seeking and safety strategies used by the non-offending caregiver;
- Help-seeking and safety strategies used by the child;
- Non-offending caregiver's employment or access to financial resources;
- Alleged perpetrator's employment status;
- Degree to which perpetrator accepts responsibility for abusive behavior;
- Availability of social supports.

e) Use the Assessment Tools for the Non-offending Caregiver, Child, and Alleged Perpetrator.

5. Planning with the Family

a) Planning for Safety with Domestic Violence

- Safety planning should always be done whether the non-offending caregiver is leaving or staying with the perpetrator.
- Involve the non-offending caregiver in the safety planning process.
- Engage a domestic violence specialist to assist in the safety planning process.
- Ask the non-offending caregiver what has been done in the past to provide safety? What has worked and what hasn't?
- Explore the benefits and disadvantages to different safety strategies.
- Instruct the non-offending caregiver to collect and gather important documents they will need if they need to relocate with the child.
- Develop a list of resources for supports that the non-offending caregiver and child may need including numbers of friends, families, and service providers.
- All plans for the non-offending caregiver should empower them and not be used to hold them accountable for the perpetrator's violent behavior in the future. The non-offending caregiver's plan SHOULD NOT be shared with the perpetrator.
- Create an action plan with steps to take in the following scenarios:
  - The non-offending caregiver notices a trigger for a violent situation or if violence begins.
  - The child needs to reach out to a safe adult for help.
  - An exit plan for the child to leave the house or hide within the house during an assault.

    Note: Be willing to change the plan based on what the non-offending caregiver says is and is not working. Some action plans may increase danger to the child and non-offending caregiver and may need to be reassessed.

b) If the Alleged Perpetrator Leaves the Home:

- Important to note that this is frequently the most dangerous time for victims and their children.
- Ongoing assessment is crucial for monitoring safety concerns, demonstrating that alleged perpetrators are held accountable for their parenting, helps further assess alleged perpetrator strengths and needs to make continued plans for the family.
- Important to observe how the alleged perpetrator treats the non-offending parent during visitation.

c) Action Steps for the Non-offending Caregiver and Child can include:

- The non-offending caregiver and child sharing a code word that when said indicates that the child needs to leave and call 911;
- Identifying the safe adults that the child can talk to about their ongoing safety at home;
- Secure places in the home where the child can hide during an incident if unable to leave the home;
- Nearby places with a safe adult the child can go to during an incident;
- Changing locks or adding security systems to the home;
- Informing friends, co-Case Managers, school personnel, and neighbors of the situation and any restraining orders that are in effect;
- Any temporary living arrangements for the non-offending caregiver and/or child;
- Seeking an order of protection;
- Meeting with a domestic violence advocate;
- Address concrete emergency needs such as medical care and childcare.

d) Work separately with the alleged perpetrator to identify action steps and behaviors that the perpetrator will participate in to protect the child. Action steps can include:

- Honoring protection orders;
- Leaving the house;
- Time-outs;
- Attending perpetrator intervention groups;
- Utilizing probation officers or intervention services to hold perpetrator accountable for action steps;
- Identify which friends and family members can also help hold perpetrator accountable.

e) Removals

All efforts to reduce trauma and safely keep children in home with the non-offending

caregiver should be made.

- Situations that may rise to the level of out of home placement include:
  - All safety planning options have been explored but are not available for various reasons;
  - The situation presents a threat or impending threat to the child;
  - The non-offending caregiver is unable to accept services or protect the child;
  - The perpetrator is unable or unwilling to make changes for the child's safety;

    Note: Refer to Policy *14.14, Removal: Safety and Permanency Considerations*, for additional information.

f) Child and Family Team Meetings

- Choose a safe location;
- If separated, arrange for the non-offending caregiver and perpetrator to arrive and depart separately as meetings may increase violence;
- Ensure there are supportive individuals there for the non-offending caregiver;
- Arrange for security and be prepared to stop the meeting if things get escalated. There may be a need to continue the meeting at another time when the alleged perpetrator can be called in over facetime;

g) Developing Permanency Plans with the Family

- The goal is to promote enhanced safety and protection for the child and hold perpetrators accountable for their abusive behaviors.
- Important to consult with domestic violence specialists for their expertise in case plan recommendations;
- Engaging the non-offending caregiver in the development of the plan empowers them and uses their expertise in making decisions around safe alternatives and services that will enhance their child's safety;
- Address any co-occurring issues or needs the family may have;
- If scheduling visitation with the perpetrator, ensure it does not violate any court order or put the nonoffending caregiver at risk of danger or intimidation.

6. Documentation

a) The case recordings should clearly identify the patterns of abusive and controlling behavior and identify the effects of the domestic violence on the non-offending caregiver and children.

b) Language is crucial in domestic violence documentation. Use non-offending caregiver to refer to the parent experiencing domestic violence. Use alleged perpetrator to describe the person who engages in patterns of abusive or controlling behaviors. Avoid any language that blames non-offending caregivers for the violence.

c) Documentation should include any collaboration between partners. This may take different forms at different stages in the CPS process including but not limited to:

- Joint investigations with DCS and Law Enforcement (LE);
- Co-located domestic violence liaisons;
- Multi-Disciplinary Teams including DV specialists (for alleged perpetrators and non-offending caregivers).

d) The following information in documentation should never be shared with the perpetrator:

- Any information in the case record or public documents pertaining to the confidential address of the nonoffending caregivers;
- Disclosures made by the non-offending caregiver and children;.
- Safety plans for the non-offending caregiver and children.

Note: If there is court involvement, some of this information may be required to be released to the court or pursuant to court order. Consult with legal prior to releasing this information.

7. Classification and Case Closure

a) Prior to case closure, the case manager and supervisor must ensure the following:

- Final risk assessments should be completed for case closure.
- The non-offending caregiver and children, when interviewed separately, report feeling safer.
- The non-offending caregiver has knowledge and access to relevant support services, information, and safety options.
- The non-offending caregiver and perpetrator understand the effects on domestic violence on the children.

Child Death/Near Death

1. *Protocol for CPS Categories and Definitions of Abuse/Neglect* Definition:

a) Child death is defined as:

- Any child death caused by abuse or neglect.
- Any unexplained death of a child when the cause of death is unknown or pending an autopsy report.
- Any child death caused by abuse or neglect resulting from the parent or legal custodian/caretaker failure to stop another person's direct action that resulted in the death of the child. Child deaths are always treated as severe abuse.

b) A near death, per Tennessee Code Annotated (TCA) 37-5-107(c)(4) is defined as a serious

or critical medical condition resulting from abuse, neglect or child sexual abuse, as reported by a physician who has examined the child subsequent to the abuse or neglect. When an initial referral or a referral on an open case contains information that suggests the child is in a serious or critical medical condition as a result of the allegation(s) or has been determined to meet the criteria for an allegation of near death as defined above, the Child Abuse Hotline selects Preliminary Near Death (PND) Indicator in the the Electronic Record System on the participants tab on a new intake or the investigative persons tab on an active case. The information does not have to come from a physician. Preliminary near deaths are always treated as severe child abuse.

2. Engagement and Interviewing

   a) Interviewing parents/caregivers

      - Interview all parents/caregivers separately and privately.
      - Move into other typical investigative questions to develop an understanding of safety and risk factors, specifically including mental health issues (symptoms, diagnoses, medications), financial situation (income, public assistance, other community resources), and discipline practices.
      - Engage with the parent/caregiver around the discussion of allegations within the referral; this does not mean reading the referral to the parent/caregiver as this may adulterate the investigative process.
      - Explore substance use with parents/caregivers. Were they under the influence at the time leading up and/or during the time of the death/PND incident? Drug screen when a reasonable suspicion of drug use and/or impairment exists. Describe in detail any observations regarding possible impairment, intoxication, or compromised ability to provide care or supervision as related to the child or children's ages and abilities.
      - Gather information about relatives, friends and significant kin that could provide resources or potential placement options.
      - Assess the parent/caregiver's protective capacity.
      - Avoid any blaming questions.
      - For infants and young children, explore the child's medical history, including the child's birth weight, was the child full-term or premature, was there any prenatal drug exposure?
      - Discuss Safe Sleep with the parents/caregivers and document sleeping arrangements. How was the child found? Anything in the bed/crib? Position of child?
      - Explore the child's health, specifically if the child has been seen by a physician recently, when was the date of the child's last physical exam, has the child's growth been tracked by a pediatrician, who is the child's primary care physician, is the child prescribed any medication, does the child have any allergies or medical diagnoses? Has the child been sick recently? If child was medically fragile, was the equipment functioning properly, was the equipment clean, and supplies available? Do the

caregivers understand how to care for special medical needs, was home health/nursing involved, was a log kept, are medications available, were specialty and PCP appointments kept?

Note: The regional DCS Nurse can provide additional medical questions to ask

- Explore the child's feeding habits, including what and how much the child eats, how often the child eats, if the child has had any changes in diet (breast milk to formula, regular to soy, formula to whole milk, etc.). How was the bottle made?
- Explore where the child stands on meeting developmental milestones.
- Develop a timeline of events for the 48 hours prior to the death/near death. Everyone who cared for the child should develop a timeline.
- Establish a baseline of what "normal" looked like for the family and anything that may have changed leading to the death/near death incident.

b) Common Circumstances:

- Involving Firearm– did LE take firearm used in incident? Are other firearms in the home? How was the incident weapon and other weapons stored? Were the children familiar with the guns in the home, show curiosity or play with the firearm in the past? Did the child(ren) know about gun safety? If ACV or other child in home was reported to have found the gun, is that area in fact accessible to the child in question in terms of age/height/ability? How and where did the child obtain the firearm? Create a safety plan around firearms remaining in the home.
- Drowning – if bathtub – how high was the water, the position of the ACV in the tub, how long unattended, was line of sight/sound maintained; age of child in relation to position they were in tub – were they able to maintain sitting up posture; were they holding on to sides and standing. If pool – how deep, could ACV swim, safety gates/fences, safety plan going forward around pool. Did any security cameras in or around the home capture footage leading up to and involving the evidence?
- Physical injury – follow Physical Abuse guidance in this Manual; if child fell from one surface or location to another, measure distance of fall and whether landing on hard or soft surface.
- Suicide – past suicidal ideations; recent behavior changes; were medications secured in the home (request any past Mental Health records/services); was a Safety Plan in place; evaluate environmental and community factors such as school, work, friends, bullying, home life, etc.
- Motor vehicle accident – were car seats secured correctly into the vehicle and child(ren) properly restrained; correct car seat for child's age/weight? Did impairment contribute? (drug screens/blood draw records). Request Tennessee Highway Patrol or Law Enforcement investigation of the accident.
- Unsafe Sleep – what are the typical sleeping arrangements; are they appropriate for the child's age; child sleeping alone or with someone; any items in the sleeping area (pillow, blanket, stuffed animal, bumper pads, bottle); is LE or Medical Examiner's

office going to do a re-enactment; request a copy of the completed SUIDI form from LE;

c) Interviewing witnesses

- Interview all other persons who may have witnessed the death/near death or have relevant information regarding the circumstances of the ACV and family, including referents, other adults or children in the home or community, professionals, or staff of other agencies.
- Topics to explore with the witnesses:
  - Last time the witness saw the child
  - The child's physical condition
  - When was the last time the witness was in the home?
  - Parents/caregivers behaviors, substance use, mental health, physical health, intellectual/developmental abilities
  - Child's mental health, medical history/condition
  - Any injuries observed on child(ren)
  - Sleeping arrangements in the home
  - Living conditions of home
  - Any other concerns regarding the family
- Interview First Responders (EMS/fire/rescue)-find out what they saw and how the family was behaving when they interacted with them. Request 911 call audio or transcript when available.

d) Observing the Child

- Death - Case Manager does not have to see the deceased ACV; if body is still at scene or hospital, LE will likely be taking photographs and documenting observations, be sure to request copies and/or summaries of whatever information they are willing to provide. Photographs are confidential and should be labeled as such.

  Note: When uploading photographs of deceased child, notate that the photographs are graphic in the subject line.

- Near-Death - observe child, note physical condition and any injuries. Document life sustaining measures being taken (i.e. ventilator, medication) Once child is able to be interviewed conduct the interview and follow normal interviewing techniques.

  Note: When uploading photographs of severe injuries notate that the photographs are graphic in the subject line

e) Interviewing the siblings/other children in the home

- Schedule forensic interviews for siblings/other children in the home as soon as

possible after a minimal facts interview has been completed

- If physical abuse is a concern, schedule skeletal surveys/medical exams on the other children
- If drugs are involved, consider hair follicle testing on all children
- Consider that even though siblings often have little to do with the actual death/near death incident, they may be direct witnesses. Additionally, siblings are usually able to provide important information regarding their home life, changes in circumstances, and insights into the behaviors and state of minds of their family members. Always take into account age and developmentally appropriate lines of questions to lessen repeat trauma.

3. Assessment of Safety and Risk

a) Current safety concerns

- Explore factors such as parent/caregiver alcohol or substance use, mental/physical health diagnosis/symptoms, potential for relapse and/or aggravation of existing issues.
- Is there formula/food in the home for the child(ren) now?
- What is the family's current financial situation and access to resources?
- Concerns for abuse/neglect
- Familial and Community violence (e.g., gang-related incidents, drug culture, ability to protect, external exploitation/pressure through social media.

b) Risk and Protective factors

- Is there a history within the family of abuse/neglect or a continuous pattern of abuse/neglect that threatens the health or safety of any child?
- Are the children in school/daycare or otherwise visible in the community?
- Are the parent/caregivers employed or do they have access to financial resources?
- Does the family have adequate and stable housing?
- What is the availability of family and community supports? Are there caring adults outside the home who can serve as role models or mentors?
- What is the parent/caregiver's level of understanding of children's needs, child development, and parenting skills?
- Explore parental characteristics such as young age, low education, developmental ability, single parenthood, large number of dependent children, and low income.
- Are there weapons in residence? Are they secured properly?
- Are medications stored properly in the home?
- Are there non-biological or transient caregivers in the home (e.g., mother's male partner)

- Explore family stressors, separation or divorce, and violence, including intimate partner violence, poor parent-child relationships, and other negative interactions.

c) Planning with the Family

- If immediate harm factors are present, as determined by formal and informal assessments, a safety intervention must be considered.
- Involve the parents/custodians in the safety planning process.
- Engage the medical professionals to assist in the safety planning process. (If Near Death- Will the child be hospitalized? For how long? Will there be any special care or diet required upon discharge?)
- All efforts to reduce risk and safely keep children in home with the parent/caregiver should be considered if possible. Situations that may rise to the level of out of home placement include:
- All safety planning options have been explored but are not available for various reasons:
    - The parent/custodian is unable or unwilling to accept services.
    - The parent/custodian is unable or unwilling to make changes for the child's health and safety.
    - The non-offending parent/caregiver lacks the ability, capacity, and/or resources to ensure ongoing child safety.
- Developing Permanency Plans with the Family
    - The goal is to promote the health and safety of the child(ren) by strengthening the ability of families to effectively parent.
    - Important to consult with the involved medical providers for their expertise in case plan recommendations, including hospital discharge instructions and ongoing dietary needs for the child.
    - The plan should focus on long-term needs as well, such as the parent/caregiver's relationship with the child and any depression or other parent/caregiver mental health needs.
    - Services included on the plan should be specific to the health and safety needs of the child and address any other risk factors, safety concerns, and needs identified by the family.
    - Engage parents/caregivers and document all efforts made to involve parents/caregivers to enhance the child's health and safety.
    - Include statements of responsibility for each party with clearly defined action steps and the desired outcomes of those steps.
    - Important to discuss grief counseling, mental health services and substance use treatment.

- Explore what assistance the family may need or want in planning funerals and/or end of life cultural events.

4. Documentation
   a) All documentation (not just main contacts) should be entered in the Electronic Record System, as per DCS policy *31.14, Case Documentation Requirements*.
   b) All case recordings entered into the Electronic Record System will be redacted and published online once the case closes. Keep this in mind with the goal of being as accurate and professional as possible in documentation.
   c) Abbreviated documentation is NOT to be utilized on death or near-death investigations.
   d) The case recordings should clearly identify the abuse and/or neglect.
   e) Documentation should include interviews with the child's medical providers, including observations, diagnoses, treatment, and any discharge instructions.
   f) Copies of medical treatment records should be obtained, relevant content documented in case recordings, and uploaded to the Electronic Record System. Utilize regional DCS Nurse consultation for understanding of medical records and evidence the records can provide.
   g) Documentation should include collaboration with CPIT partners and outcome of CPIT team meeting. Upload the CPIT form into the documents section.
   h) Document any services put in place to reduce risk including services offered, refused and/or court ordered, implementation of services, participation in services, follow up with service providers, and notification to provider that DCS case is closing.
   i) Documentation should contain detailed entry of information obtained from the children, parent/caregiver, siblings, and all witnesses.
   j) Autopsy should be summarized in documentation and uploaded into the Electronic Record System.

5. Classification and Case Closure
   a) Final Safety Assessment and/or Family Advocacy Support Tool (FAST) should be completed for case closure regardless of whether there are any surviving children.
   b) The parents/caregivers have knowledge and access to relevant support services and information.
   c) A closing case summary is completed that clearly identifies the evidence which was used to justify the classification decision in detail and states the outcome of the case. A closing summary is a summary of the investigation and not a "copy and paste" of the interviews.
   d) Closing summaries should NEVER be entered in case recordings (in draft or otherwise) until review and final approval has been given by the Executive Director or designee. Complete the closing summary on a Word document and send to Team Leader for approval. The Team Coordinator then reviews/approves, and the Executive Director, or

designee, reviews and provides final approval.

e) Final case closure approval will come from the Executive Director or designee.

6. Staff Support

   a) Information regarding staff support is provided by the Director or designee during the 48hr Debriefs for child death and near-death cases.

   b) Support such as Emotional Wellbeing Solutions, Critical Incident Debriefing, and specialty training are always available. Staff will be encouraged and given the time and ability to access these resources when needed.

   c) Staff is encouraged to reach out any time during or after the investigation for additional support from peers, regional leadership, and other executive leadership as needed. Staff's personal wellbeing is of utmost importance during the navigation and experience of these challenging and often emotionally difficult cases.