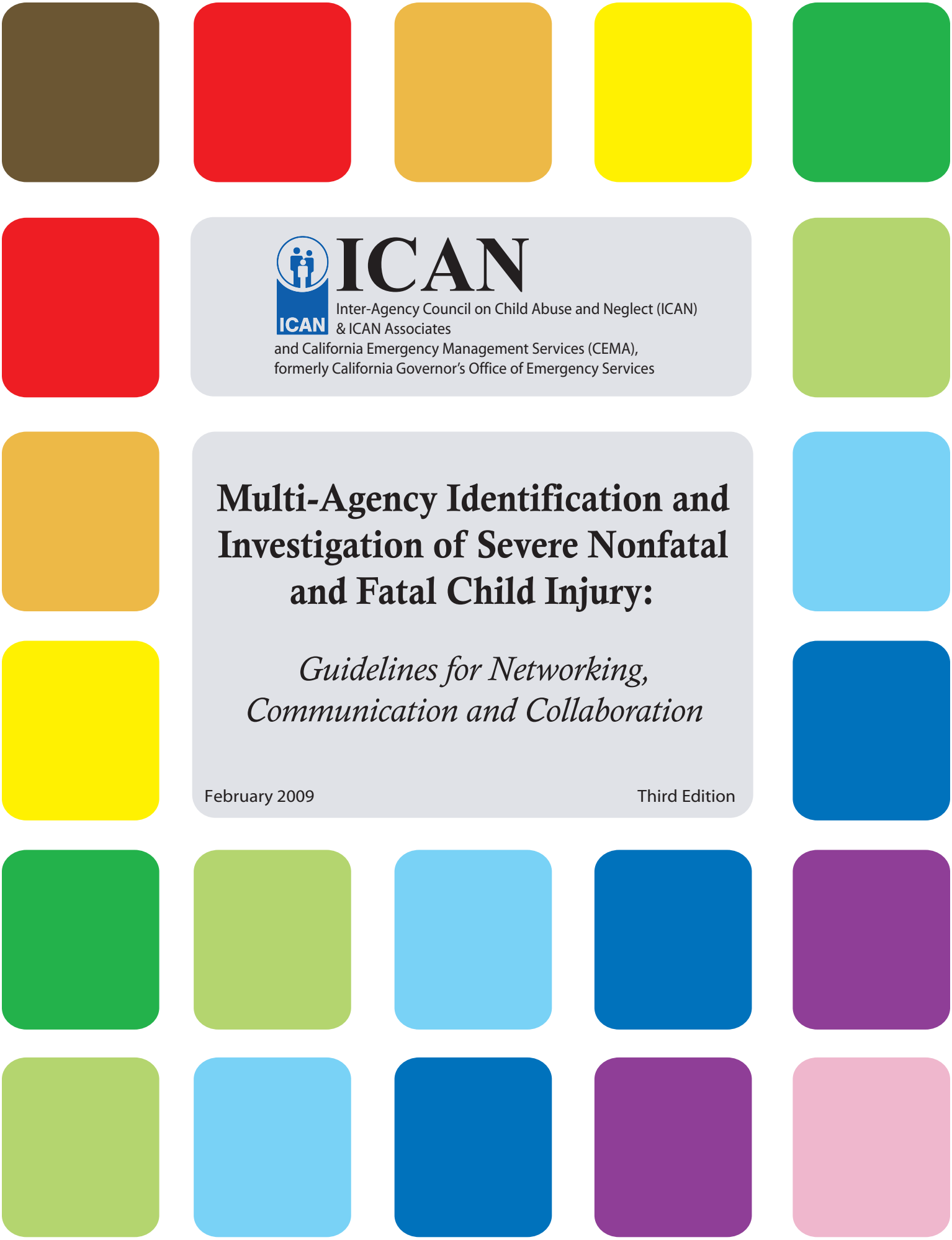

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Inter-Agency Council on Child Abuse and Neglect (ICAN)
& ICAN Associates
and California Emergency Management Services (CEMA),
formerly California Governor's Office of Emergency Services

Multi-Agency Identification and Investigation of Severe Nonfatal and Fatal Child Injury:

Guidelines for Networking, Communication and Collaboration

February 2009

Third Edition

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Multi-Agency Investigation and Identification of Severe Nonfatal and Fatal Child Injury: Guidelines for Networking, Communication and Collaboration

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The development of **Multi-Agency Investigation and Identification of Severe Nonfatal and Fatal Child Injury: Guidelines for Networking, Communication and Collaboration *(The Guidelines*)** has been a successful collaborative effort, including valuable contributions from professionals from all over the United States.

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It is through the process of networking, communication and collaboration that we realize the power of teamwork and our mutual commitment to improving the health, safety and well being of children and to reduce preventable child fatalities.

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Multi-Agency Identification and Investigation of Severe Nonfatal and Fatal Child Injury: Guidelines for Networking, Communication and Collaboration

Case: A young toddler has massive head trauma poorly explained by the parents and childcare provider. He is not reported as a suspected child abuse victim. As with most hospitals, there is no child abuse SCAN team. If the child dies, the case might go to the local Child Death Review Team where records of previous violence could be identified and experts in child abuse injury might help identify the source of trauma. Two previous hospitalizations have been missed, including one for head trauma and one for burn injuries. All are recorded in his health insurance records, but such claims are not reviewed for possible child abuse. He is, therefore, discharged to a rehabilitation program with brain damage and re-exposed to his abusers.

Hospitals and health care systems, including public health, are not consistent in their responses to possible child abuse. The following Guidelines will address all hospitals that have pediatric services, with a particular focus on child trauma services.

INTRODUCTION

Multi-Agency Identification and Investigation of Severe Nonfatal and Fatal Child Injury: Guidelines for Networking, Communication and Collaboration (The Guidelines) advocates for the systematic review of severe child injury by communities and individual hospitals. *The Guidelines* focuses on nonfatal injuries, understanding that severe injury is on a continuum that may end in death. It is meant to inform better policies, practices and overall understanding of injuries in children to achieve the maximum rate of child abuse detection, intervention and prevention. Since nonfatal injuries greatly outnumber fatalities, the most immediate goal and one of the most serious challenges will be in managing the significant increase in potential cases to be reviewed.

Handling this increase in cases reviewed will require strengthening community and agency networks and establishing better pathways of communication and collaboration. Necessary components will include more flexible team models, sharper definitions for case selection, wider training within and across agencies, and greater coordination of data collection and information sharing.

The Guidelines advise and assist in this process by (1) outlining best practices and models for hospitals with pediatric services to strengthen their child protection protocols; (2) combining the lessons learned from multi-agency child fatality review teams with those learned from multi-disciplinary investigation teams, (3) presenting them in a concise and user-friendly format, and (4) incorporating electronic links to websites and library for more advanced discipline-specific protocols, background information and other references.

Background:

Child abuse, even with physical injuries, is not a medical condition. It is a social phenomenon. Environmental and care giving factors in a child's life are better determinants of a differential diagnosis of abuse or not abuse than are the physical conditions alone. Making a finding that a child has been abused and needs protection requires the cooperation of professionals from many disciplines. [90]

Multi-agency collaboration has been the gold standard for the investigation and review of child maltreatment for many years. The first teams were established in the late 1950s at Childrens Hospital Los Angeles and Children's Hospital of Pittsburgh following publication of "The Battered Child Syndrome" by Kempe and colleagues. [79,91] In 1974, the Child Abuse Prevention and Treatment Act included funding for multi-disciplinary centers, thereby encouraging the development of multi-disciplinary teams such as Child Death Review Teams (CDRTs), hospital Suspected Child Abuse and Neglect (SCAN) Teams and Multi-disciplinary Investigation Teams (MDTs), especially in the form of Child Advocacy Centers (CACs). [27,106,108, 110,112,113] In 1998, pursuant to the *California Children's Justice Act*, California legislated that all counties establish a multi-disciplinary policy for the response to all suspected child abuse and neglect reports. Throughout these years, the efficacy of multi-agency protocols has been well documented. [27, 79, 91,106,107]

A collaborative approach provides the optimal environment for professionals to share their information and expertise for the benefit of a specific child, the child's family, and his or her community at large. The impact of such multi-agency teams, especially when in concert with established multi-disciplinary teams has proven to be considerable.[105,106]

Many lessons can be learned from the way these teams function, especially when examining their close collaboration with forensic medical experts, and their protocols for information sharing and coordinated collection of evidence and interviewing. [23,104,106] Unfortunately, MDTs and SCANs are not in all jurisdictions or all hospitals, thus limiting the influence they might have in effecting outcomes for specific children and the community at large.

Rationale:

The review of child fatalities is encouraged in California. Every county either has a team or joins with a neighboring county. All counties currently are associated with a team and are under one of the eight regional groups of the State Child Death Review Team. Outside California, a few states have expanded their CDRTs to include severe nonfatal child injuries. California has not.

Encouraging communities to consider the review of severe nonfatal injury cases will add a dimension to community prevention strategies and policy decisions by taking a closer look at practices and policies within hospitals, as well as the quality of collaboration with outside agencies. Unlike fatality review, the review of severe nonfatal cases sheds light on how hospitals and medical practitioners fit into the overall system of the identification and reporting of child maltreatment. In fatality reviews, Coroners and Medical Examiners are the anchors to the process. Often the participation of hospital or private medical professionals is limited and their specific points of view not fully incorporated due in part with the wide array of relevant medical specialists. [108] In non-fatal reviews and investigations, however, their role is central.

Focusing on nonfatal child injuries results in medical professionals playing a prominent role in any community multi-agency collaboration. It also heightens the need for medical facilities to have a well-defined internal SCAN team to facilitate the multi-agency communication. The SCAN team members coordinate hospital medical staff in the identification and reporting of suspected child abuse as well as act as hospital liaisons with the outside agencies investigating the suspected abuse.

As of 2008, California has only 18 accredited Child Advocacy Centers (CACs) with full teams, though 14 others are in the development stages.[80, 103] The number of more loosely defined MDTs and hospital SCAN teams is hard to pinpoint, although each of the ten Emergency

Medical Services for Children (EMSC) approved Pediatric Trauma Centers in California, and any Children's Hospital Advanced or Centers of Excellence are expected to have child protection (i.e., SCAN) teams. Disappointingly, community hospitals are required only to have a protocol for how to make mandatory child abuse reports in their facilities. To their credit, a few community hospitals organize periodic reviews of cases where a child abuse report was made, and refer to this review group and process as a SCAN team. The active involvement of these team members in acute cases, however, is less clearly defined.

In Los Angeles County, hospital based SCAN teams have been steadily on the decline primarily due to funding challenges. In 1994, there were nearly 43 hospitals that reported having a SCAN team; in 2007 only 26 remained as active teams—and many of those do not meet regularly. It is suspected that this reduction is common across the state in community hospitals. Any decrease in hospital-based SCANs weakens the collaborative assessment and investigation of cases of severe nonfatal injury.

However, there is evidence that the trend may be shifting back. In 2006, a number of medical associations promoted greater awareness of and systemic response to child abuse and pediatric trauma.

One example is The National Association of Children's Hospitals and Related Institutions (NACHRI) publication of "Defining the Role of Children's Hospitals in Child Maltreatment" [79] —a comprehensive set of guidelines to help Children's Hospitals to build, grow and improve sustainable child abuse and neglect programs.

The American College of Surgeons accreditation criteria for Level I and II Pediatric Trauma Centers in 2006 also required they have pediatric social work and child protective services, pediatric injury prevention and community outreach programs, and pediatric trauma education programs. [92]

That same year, the American Board of Pediatrics (AAP) approved a credential for the subspecialty in child abuse pediatrics. [79]

Also in a recent policy statement, the AAP highlighted the importance of Pediatric Trauma Centers as a key component in trauma care systems in meeting the needs of injured children. It stated, "…younger and more seriously injured children have better outcomes at a trauma center within a children's hospital or at a trauma center that integrates pediatric and adult trauma services." [88]

The shift towards greater involvement of medical professionals in child maltreatment programs provides an opportunity to improve the identification of inflicted trauma by increased screening and review of cases. Medical professionals will need to talk with each other more for consultation and training.

But this shift also demands multi-disciplinary collaboration with outside agencies charged with the investigation of child abuse whether this is accomplished through participation in a hospital-based SCAN team or a community-based MDT, or through less formally structured contacts with individual investigative agencies.

The current state of practice in identifying, reporting and investigating severe nonfatal child injuries is still a work in progress. Medical professionals need to know more about the process of investigation. Investigators as well as medical professionals need to know more about the process of identifying inflicted injuries.

The Guidelines was developed in response to these needs. It consolidates the core values, skills and lessons of multi-agency teams so that professionals can be more widely employed in evaluating injuries to children. This means that the process of child injury identification, assessment, evaluation and investigation will function whether there is a formal CDRT or MDT in a given community, or a more loosely defined network of agencies. Any involved professional should possess much of the same expertise as the professional formally assigned to a team.

No one model or type of multi-agency review fits all hospitals or communities. However, whether the team is a community review team, a hospital-based SCAN team, or a combination, the necessity for the establishment and continuation of functioning teams for severe nonfatal child injuries is undeniable. Just as medical examiner/coroners are the anchoring professionals in Child Death Review Teams, medical forensic experts in child maltreatment anchor Severe Nonfatal Child Injury Teams. [27]

Challenges and Limitations of Teams

The advantages of multi-agency or hospital SCAN teams are indisputable. They are good investments and can be accomplished within the daily routines of the professionals involved. There are, of course, certain challenges. Keeping teams functional and efficient does require coordination. They require administrative acceptance and commitment from all the relevant agencies in order to maintain ongoing participation from the members. Sometimes teams must operate with a combination of official representatives assigned from some agencies along with more loosely connected liaisons from other agencies. [107,108,111,112]

Member turnover can slow progress. As members move on, the team leadership must conduct orientations for new team members as well as continual team-building activities. The loss of funding for a team or budgetary cutbacks at one of the member agencies can impact the ongoing process.

Without an administrative commitment to multi-agency collaboration, teams can struggle in the face of these challenges. Often the success of a team rests on one committed professional at one of the agencies who has the passion and clout to hold the team together. When that person retires or is promoted, the team may falter.

Not all multi-agency teams are alike; they differ in jurisdiction, team membership and/or type of child abuse. This lack of uniformity is unfortunate for many reasons: 1) not every jurisdiction or hospital has a team, 2) when there is a team available, only a select number of professionals from each agency can be assigned to it (limiting the number of police, social workers, physicians or attorneys who can be trained to the same level of expertise at any given time), and 3) teams focus on different types of child maltreatment, i.e., CDRTs only focus on fatalities and many MDTs focus primarily on sexual abuse. The result is a checker board view of the status of child maltreatment in any community.

Furthermore, the goals of CDRTs and MDTs differ. CDRTs are concerned more with the larger picture of prevention and policy-making, while MDTs are more focused on the investigation of a particular case.

A potential barrier to the review of severe nonfatal injuries in children can be confusion around confidentiality requirements for a child that is still alive and receiving care. Any multi-agency or hospital-based review team should clearly describe the legal options for all of its member agencies in order to avoid an overly-cautious approach to information sharing.[32]

It is also true that a retrospective review of nonfatal injuries in a hospital may include cases where child abuse was *not* suspected previously and no report made. It is a good idea to get further clarification on how to handle information sharing or any delayed reporting. One option might be for hospitals to consider organizing the review of severe injury into their medical quality assurance reviews (MQR). Within the MQR system, the patient identifiers remain confidential, but the lessons learned from the sample reviews of individual cases can be used to modify hospital protocol to improve the response to child injuries and the recognition and reporting of child abuse.

Solutions to these challenges will require more creative and flexible configurations of both intra- and inter-agency alliances. Some agencies may have to design review teams that best fit their internal needs while at the same time coordinate with multi-agency regional teams. To that end, *The Guidelines* condenses the valuable lessons from each type of team in a user-friendly, easily understandable and accessible format.

The Guidelines advocates that specialists in child abuse and pediatrics should be central to the process of identifying and reporting suspicious physical injuries to children, whether or not the specialists are assigned to a hospital-based SCAN team or a community review team. *The Guidelines* also recommends that a data collection and surveillance program internal to a hospital or in the local community be undertaken in order to ground the overall assessment and investigation of suspected child abuse in evidence.

Goals:

The goal of *The Guidelines* is to establish a dynamic tool that outlines basic best practice standards that improve community agencies in the identification and investigation of children with severe non-fatal injuries to prevent subsequent, perhaps fatal, injury. They are designed to:

- Promote the building of inter- and intra-agency networks, especially to facilitate the sharing of information and expertise;
- Strengthen hospital and community management of severe child injuries through data collection and case review;
- Encourage the development of multi-disciplinary and/or multi-agency teams both within hospitals as well as communities to review nonfatal child injuries to ensure better outcomes for children as well as propose recommendations for prevention;
- Clarify roles of responsibility, authority and leadership of each agency in order to promote a better understanding of their interlocking roles.

Scope and Definitions:

For the purposes of *The Guidelines,* the term “severe child injury” will refer to a child who is in need of inpatient medical care as a result of that injury. This definition is similar to that used by nonfatal review teams in Maryland and New Jersey who use the term “near fatality” as defined in the Child Abuse Prevention and Treatment Act (CAPTA):

> “[T]he term “near fatality” means an act that, as certified by a physician, places the child in serious or critical condition.” [93]

Oklahoma also has been reviewing nonfatal injuries for several years. They look at "near death incidents that resulted in a child being admitted to the hospital in serious or critical condition due to alleged abuse and/or neglect." [51] This definition used by Oklahoma differs somewhat from that used in *The Guidelines* in that cases must have already been concluded as abuse or neglect before being referred to the team.

One recent attempt to fine-tune the definitions of child maltreatment, including physical injury, is the *Child Maltreatment Surveillance: Uniform Definitions for Public Health and Recommended Data Elements* [11] by the Center for Disease Control and Prevention (CDC).The expressed purpose of this uniform code is to aid in the collection and coordination of data on child maltreatment. In the area of physical injury, it proposes detailed data elements: "injury characteristics", "mechanisms of harm/injury", "external physical injury" and "internal physical injury" [pp. 87-91]. But the *Uniform Definitions* recognize that there are many more specific descriptions of injuries that are not easily captured in a general framework. The CDC notes that the collection of necessary detail underlying child injuries can be time-consuming to obtain and are, therefore, difficult to capture in any surveillance system. By and large, such details have to be collected from individual case records and charts.

Until the child maltreatment community can complete research to flush out the injury characteristics in the CDC *Uniform Definitions*, they can only act as an operational backdrop for nonfatal injury reviews and data collection; these definitions do not, however, offer a specific definition. In fact, it is precisely this specificity of injury characteristics that Section 2 of *The Guidelines* proposes hospital and community nonfatal review teams begin to examine.

Further, *The Guidelines* does not utilize the descriptors "accidental" or "unintentional" which presuppose culpability. Although "intent" is an important concept in child abuse investigation, it is a conclusion, like a final diagnosis, that needs to be reserved until a review or investigation is completed. Any attempt to distinguish intent before examining the details of any child's injury risks bias and flawed investigations by the medical professional or child abuse investigator that could result in faulty conclusions or unexpected consequences.[108]

In a similar vein, Peterson and Brown [84] pointed out that when looking into injuries, professionals make two erroneous assumptions: (1) inflicted injury is readily separated from non-inflicted injury in practice and (2) there are clear standards to evaluate when a non-inflicted injury is unintentional as opposed to neglectful. Moreover, Christoffel and Scavo Gallagher [81] have noted that most people, including many professionals, "consider injuries to be the result of random, uncontrollable factors that are largely beyond human control – so called "accidents" or "bad luck". Such misconceptions lead to improper generalizations and can have a negative impact on an investigation or on the wider understanding of the risks to children.

It is precisely these easily misconstrued concepts of "intentional", "accidental" "unintentional", or "non-inflicted" that lie at the heart of the challenge to understand "injury" in the context of child physical abuse, and therefore, will not be included in the definition of "severe nonfatal injuries" for *The Guidelines.* Perhaps as research using the CDC *Uniform Definitions* [11] comes forth, a more precise definition can be tailored and put into practice.

In the meantime, *The Guidelines* recommends that with each assessment and investigation of the injury to a particular child, it will be necessary to look at his or her unique set of circumstances. Similarly, each hospital or community review team should collect specific data and review cases from within their own facilities or jurisdictions so that the conclusions drawn

will fit better and provide a more relevant feedback loop for future assessments, investigations and training.

Finally at this point *The Guidelines* do not address the special considerations that may be required for the assessment of self-inflicted injuries or suspected child sexual abuse. However, the principles presented here would still hold. [105, 106, 107,108]

Organization of *The Guidelines*

The Guidelines is designed to be a dynamic document outlining the very basic values of multi-agency review and investigations. It will need updating as the understanding of child maltreatment or legal mandates change. It is divided into four sections. Each section can also stand alone for reference or training depending upon need or interest.

Section 1: Best Practices for the Medical Identification of Severe Nonfatal Injury

This section is directed primarily to medical and social services professionals providing pediatric services. It outlines best practices for basic child protection protocols in medical settings to improve the identification of inflicted trauma. It is assumed that some pediatric hospitals have already developed child protection programs that surpass the proposed practices outlined in this section. This section advocates for an increase in awareness and practice through medical facilities providing services to children so that they might partner with hospitals with more refined programs while strengthening the child protective protocols in their own facility.

Section 2: Model for Hospital and Community-based Severe Nonfatal Injury Review

This section sets up a framework for developing systems to review traumatic injuries of children within hospital and regional settings.

For hospitals, the framework starts with a simple approach to (a) surveying the cases of child injury that present to their facility for a specific period of time and (b) calculating the percentage of those cases that received a child abuse report. From this baseline, methods are suggested for hospitals to refine the examination of severe injury cases in order to learn more about specific case characteristics that can, in turn, help the hospital refine their child abuse protocol and clinical practices, establish hypotheses for research, or guide community partners in prevention strategies. This surveillance process will lead to an intake method for identifying specific child injury cases or class of cases for community severe nonfatal review teams.

For communities, there is a suggested framework, similar to that of child death review teams. However it addresses approaches to expanding beyond the Pediatric Trauma Centers or Children's Hospitals to smaller community hospitals.

Section 3: Fundamentals of Investigation of Severe Nonfatal and Fatal Child Injury

This section distills the best practices of multi-agency team investigations into ten steps. Whether or not a professional in the field of child maltreatment is officially assigned to a multi-disciplinary team, it is expected that he or she work from a multi-agency perspective. They are part of a team, even if they are not assigned to one.

When professionals are assigned to a multi-agency team, they quickly sharpen their own assessment or investigation skills and develop a better understanding of the child protection system in general. This third section *Fundamentals of Investigation of Severe Nonfatal and Fatal Child Injury* attempts to outline the core values and key investigation principles so that professionals newly assigned to a team or ones not on a formal team can be better informed and, perhaps, perform their duties more collaboratively and effectively.

The *Fundamentals of Investigation of Severe Nonfatal and Fatal Child Injury* is divided into ten steps. Each of the ten focuses on a different aspect of an investigation from a multi-agency point of view. It may best be used for orientation to multi-disciplinary teams, training or agency protocol development.

Section 4: Resources

Supplemental and bibliographic references are listed at the end of the printed copy of *The Guidelines*. They also will be available as links in the electronic version. There are three types of references:

The Guide to Reporting and Sharing Information on Abused Children is a special appendix. It is a user-friendly summary of relevant state and federal laws about confidentiality, privilege and information sharing was complied. It is an extremely useful tool. It is not intended as legal advice for any particular case, but as a general guide.

Electronic Hyperlinks are provided in the on-line version. They link the user to relevant websites and protocols that relate directly to the identification and investigation of child fatal and nonfatal injuries. This system will allow individuals who access *The Guidelines* on-line to click on icons throughout the body of the document and go directly to specific websites or PDF files with advanced, detailed information about the topic being discussed in the body of *The Guidelines*. A list of the websites is also provided at the end of the printed copy.

A standard bibliography of texts and periodicals references is included.

Section 1: Best Practices

Medical Identification of SevereNonfatal Injury

Best Practices for the Medical Identification of Severe Nonfatal Injury

Child Protection in Medical Settings

Challenges:

Individual Practitioners:

Detecting, evaluating and reporting child abuse by medical professionals can be arbitrary and often missed as a factor in severe injury. Children can die and hospitals can be liable. Many studies have sought to uncover the reasons behind the inconsistency of medical reporting of child abuse.[83,86,87,94]

The reasons for this are related to different levels of training, experience, motivation and bias of individual clinicians.

There is evidence that clinicians vary in their interpretation of reportable maltreatment and the threshold for reasonable suspicion. Distinguishing between "reasonable suspicion" and a clinician's "lack of certainty" can be a barrier to reporting. The mandate to report can be experienced by physicians as an "all-or-none" proposition that does not appear to allow for the usual medical practice of consulting. [82]

Confusion over this distinction results in some clinicians not calling law enforcement or CPS when they first suspect that the injury maybe due to abuse or neglect. Instead they wait until the full differential diagnosis is completed. When clinicians overextend the medical investigation and delay reporting to the authorities, evidence at the home or at the injury scene may be lost, the investigation impaired, and the child remain at risk. Finding a satisfactory balance between timely reporting and effective consultation and diagnosis may come after closer collaboration and communication by medical and non-medical professionals.

Decisions to report are also complicated by an individual clinician's personal bias about child maltreatment and the characteristics of abusive families. Some may report patients on Medi-Cal or without insurance and overlook those with private coverage believing that child abuse is a problem primarily seen in lower socio-economic homes.

Some physicians may not report a private patient because they allow their familiarity with the family to interfere with the recognition of red flags. They might also think they can manage any family problem more effectively than outside agencies can. A decision not to report is frequently based on a clinician's previous experience with law enforcement or CPS. If a physician anticipates negative consequences or ineffective intervention for the child or family, they may seek an alternate response to reporting, thereby bypassing the legal mandate.[86,87]

Most of the regulation for reporting child abuse is directed at the individual health practitioner with the potential for fines and incarcerations. The Medical Board of California MBC can address failure to comply with the law including the child abuse reporting law. Those regulations have seldom been acted on.

Medical Facilities:

The hospital setting itself may complicate the detection and reporting of child abuse. Hospital legal advisors may have a very cautious interpretation of patient confidentiality. Due to financial concerns some hospital administrators may be reluctant to establish a fully staffed SCAN team or to hire a forensic expert. They may see a child protection program as optional and choose instead to consult with experts at other hospitals.

Hospitals are complex facilities. The way a hospital sets up its child abuse protocol or designates child abuse experts helps determine the overall effectiveness of detection and reporting. Such programs are commonly created by the initiative of a few individuals. The threat of liability for failure to report will influence how each hospital will organize its reporting protocol. Medical costs are a major factor in the availability of medical services including the detection, evaluation and reporting of suspect child abuse.

In some facilities, the physician or social services child abuse experts are isolated in one department—typically in the Emergency Department. It is more likely that a severely injured child who presents in the E.D. as a trauma case will be screened for abuse, whereas a child admitted directly into general, or even intensive care, pediatrics units will not. The latter may even remain separate from the hospital's established child protection programs (e.g., SCAN team, protocols).

Some hospitals de-emphasize child protection programs. For example, many facilities that provide specialized treatment such as for burns, rehab or HIV may rely on the referring hospitals or clinicians to have reported any suspected abuse or neglect rather than set up their own child abuse programs.

Medical professionals are central to the effective identification and assessment of severe injuries in children. The key is setting up well-organized systems in hospitals that improve the detection of possible child abuse or neglect. Regardless of the particular size or configuration of a medical facility, ideally there should ideally be an organized system or protocol that screens all children for possible child abuse no matter where they first present or are admitted.

Hospital Standards for Services to Children:

There are a number of medical associations that have specific standards for hospital services in hospitals treating children with traumatic injuries. These various sets of standards operate separately and do not constitute an agreed upon set of principles child protection programs.

National Associations & Standards:

- The American College of Surgeons sets national standards for trauma centers that certify hospitals with status as level one, two or three and with status for pediatrics and or adults. [92]

- The American Academy of Pediatrics has a policy statement of the management of pediatric trauma that advocates for "comprehensive cooperation" of emergency medical services, trauma, and disaster response systems for a region or state to meet the unique needs of injured children. [88]

- The National Association of Children's Hospitals and Related Institutions, NACHRI sets guidelines for basic, advanced and centers of excellence. The California Association of Children's Hospitals is a separate organization. Both have acknowledged the leadership function that children's hospitals have in the area of child abuse identification and prevention. [79]

California Associations & Standards:

- The Joint Commission on Accreditation of Healthcare Organizations, JACHO enforce standards for hospitals to be licensed. They review protocols and charts for multiple factors. Training programs for health professionals including internship, residency and nursing standards are monitored by other organizations.

- California Emergency Services for Children, EMSC with local EMS addresses level 1 and level 2 pediatric trauma centers. [85]

- California Children's Services approves the status of some Pediatric Intensive Care Units, PICUs. [97]

Regional and Individual Hospital Programs:

- Local authorities may designate hospital based programs (e.g., LA County designates Emergency Departments Approved for Pediatrics (EDAP) that operate as a trauma network for children.) [98]

- Certain hospitals may house or provide forensic medical services to a Child Advocacy Center (CAC) or multi-disciplinary team (MDT)—often contracted by law enforcement or CPS agencies. [80]

Organizing a Hospital Child Abuse Protocol

Level of Pediatric Services

Each of the associations listed above have standards for treatment of pediatric trauma or services. But not all medical settings require the same degree of expertise or infra-structure in the assessment of child maltreatment. Some hospitals provide a full range of services to infants and children; others provide only basic care or specialized care.

There are many classifications and recommendations for facilities providing pediatric services – all of which roughly relate to the three divisions suggested in *The Guidelines:* None of these classifications are fixed but better understood as high points along a continuum of services.

For the purposes of *The Guidelines*, three basic levels are identified. Each represents a different need for a child protection program or SCAN protocols.

- *Minimum*: Outpatient or Rehab facilities, General Emergency Departments
- *Moderate:* Hospitals with Pediatric Units, Pediatric Intensive Care Units, Pediatric Emergency Departments or Special Trauma Units for Burns or Orthopedics
- *Maximum*: Hospitals approved as EMS Pediatric Trauma Centers, Children's Hospital Centers of Excellence, or Hospitals approved for extensive pediatric surgical services.

Best Practice Strategies for Hospitals

[See Appendix: "Assessment of Child Abuse & Neglect in Medical Settings"]

For Minimum Pediatric Service Facilities

- Formulate and use a well-defined in-house child abuse protocol and mandated reporting process
- Schedule periodic training on suspected child abuse identification, assessment, treatment and mandated reporting topics
- Employ daily screening of the admissions by designated MD, nurse or social worker experienced in the identification of child maltreatment
- Log and track the report cases of suspected child abuse
- Have referral or transfer mechanism to forensic experts and consultants in child maltreatment
- Establish liaisons with community child abuse investigators from local law enforcement and child protective services agencies
- Identify medical or social service staff experienced in child maltreatment for as needed SCAN consults and reviews (recommended at this level)

For Moderate Pediatric Service Facilities (All listed above plus)

- Establish communication links to hospital social services as well as other outside forensic medical experts.
- Organize hospital-based SCAN team with multi-agency participation from law enforcement, child protective services and mental health (others as needed) (recommended at this level).

For Maximum Pediatric Service Facilities (All listed above plus)

- Have full time child abuse experts on staff (e.g., Board Certified physicians when possible).
- Participate in community-based multi-agency child abuse activities: review teams, prevention programs, advocacy events and/or legislative or policy-making initiatives.
- Provide training, education and consultation to other medical or community agencies.
- Collect or assist in annual data and systems improvement reports to hospital and community agencies.

Improved Risk Management and Medical Quality Assurance Programs

- All medical professionals are mandated reporters of suspected child abuse and neglect.
- Established protocols and designated medical personnel experienced in child maltreatment improve compliance with reporting laws and assure cases are evaluated consistent with various hospital standards (e.g., NACHRI, EMSC).
- Better protocols and expert staff improve overall medical services to children through on-going staff training and effective community collaboration.

Best Practices for Medical Networks

- Inherent in these three levels is the recommendation that the hospitals with maximum pediatric services take a leadership role for consultation and training on the identification of inflicted injury.
- Ideally each hospital that provides pediatric services should partner with one or more pediatric trauma center, Center of Excellence, or hospital with pediatric specialists.
- The manner and structure of such partnerships should be formalized in the basic child abuse protocol for each medical facility.
- The needs of the particular region may determine how these partnerships configure. There is no one approach. Hospital linkages and partnerships will reflect the geographic and distribution of expert medical professionals. Urban areas with many maximum level pediatric hospitals will not have the same constellation as rural areas with fewer maximum level pediatric hospitals that may also be farther away or even across state lines.

Key Elements for Child Protection Protocols in Medical Settings

Recognition and reporting of suspicious injuries may depend on the attitude and experience of the medical staff. A strong hospital-based program can raise the level of response. A hospital needs a protocol for child protection that is well-defined, introduced to all new employees and reinforced with all medical and social services practitioners periodically. Each hospital will need to tailor their protocol to fit the pediatric services they deliver.

Choice of Program Components

- Hospital administration may include a basic child abuse prevention program as part of their responsibility.
- Hospital-based SCAN teams are the optimal standard of practice for overcoming the barriers to effective recognition and timely reporting.
- Associating the child abuse protection program with the hospital Medical Quality Assurance Reviews or Risk Management can provide some quality control and may temper hospital liability.
- Out-reach to other agencies to continue relationships for child abuse intervention or prevention activities can help with other issues including the good will of the community.

Child Abuse Experts:

- The National Association of Children's Hospital and Related Institutions (NACHRI) uses the term "child protection teams" and suggests *at a minimum* they might include one physician with expertise in child maltreatment who:
  - may not be fully dedicated full-time to this function
  - will coordinate medical and social services staff trained in child maltreatment
  - has a good working knowledge and relation to pediatric specialties and units as well as outside community agencies.
- Pediatric centers should have at least one full-time dedicated expert physician:
  - A pediatrician with extensive experience or, perhaps, certification, or
  - Pediatric trauma surgeon or specialist in emergency medicine, or
  - Pediatric intensivist
- Other professional experts to include:
  - Experienced or trained nurse practitioner and RN
  - Experienced or trained medical social worker
- General hospitals with no child abuse expert:
  - A specific designated social services staff trained in child abuse and neglect
  - A designated local or regional child abuse expert as a consultant
  - An established protocol for immediate consultation

Hospital SCAN teams:

- One department (e.g., Emergency) or centralized with connections to all departments treating children
- Official hospital status with clerical and other support to make the team more viable
- Full Multidisciplinary multi-agency teams are the standard but not always possible.
- Minimal membership commonly includes:
  - Physician
  - Nurse
  - Hospital social worker to act as liaison to Child Protective Services and Law Enforcement
- Extended members would include:
  - CPS representative
  - Law enforcement representative
  - Multiple medical specialists (e.g., radiologist, ophthalmologist, orthopedist)
  - Mental health (e.g., psychiatrist, psychologist, licensed clinical social worker, marriage and family therapist, child life specialist)

Confidentiality and Exceptions for Child Abuse:
[See Appendix: "A Guide to Reporting and Sharing Information"]

- Child Abuse Prevention and Treatment Act of 1974 (CAPTA) allows professionals working on cases of suspected child abuse to share information under specific multidisciplinary circumstances.
- This information sharing is mirrored in California Codes: Penal Code 11167, Welfare & Institutions Code 18951 and 830. [75,77]
- Communication about child abuse prevention or investigation is an exception to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Suggested Duties for Experts or SCAN Team:

- Oversee the mandated reports to police and CPS
- Provide immediate consultation whether on-site or at regional pediatric trauma center
- Create strong links with community investigative agencies: police, CPS, prosecutors
- Create professional network with various specialists and forensic/trauma experts within or outside the hospital
- Coordinate the contacts between police and CPS workers and appropriate medical and social services personnel working on the case
- Monitor documentation of observations, questions, diagnoses and opinions in the chart to minimize inaccuracies or unnecessary confusion for investigators or later court testimony.

- Establish a periodic internal review and/or surveillance system for injury cases that meet criteria as high-risk for inflicted trauma and compare with those cases reported.

- Help develop and implementing practice guidelines, diagnostic pathways or decision-trees that outline high-risk characteristics associated with child maltreatment and inflicted injuries. They should give clear directives for: [See Appendix: "Traumatic Injury <12 Months Pathway"]
  - Mandated reporting
  - Timely consultation
  - Medical screening, tests and follow-up procedures

Training:

Some minimal standards may be set for different staff training requirements. Some hospitals have formal training programs and may offer special training including a fellowship. The pediatric boards may help formalize this process.

- Provide frequent training by medical and/or social services professionals experienced in child abuse and neglect on topic such as:
  - Current findings and research on inflicted trauma or high risk injury profiles
  - Non-medical socio-behavioral aspects of child abuse and neglect
  - Reasonable suspicion and the duty to report.
  - Current literature on the characteristics of injuries, likely etiology or mechanism, guidelines for care and procedures
- Introduce hospital child abuse experts to wider hospital staff through routine facility-wide training on the in-house child abuse protocol and mandated reporting in general.
- Invite community professionals from criminal justice and child protective services to train hospital staff on their agency investigation needs, protocols and standard practices.
- Encourage and allow outside educational opportunities at conferences or workgroups.

Screening and Case Review for Child Abuse

Screening of Serious Nonfatal Injuries

- *Screening* describes the evaluation of acute cases by experienced medical or social services staff with the specific intent to rule out child abuse or neglect.
- Daily screening mechanism should be included in the child abuse protocol of all hospitals providing medical services to children with serious injuries.

Screening of Acute Cases from Emergency Departments (ED)

- Conduct daily screening of all admissions for serious injury.
- Screen by age, mechanism, severity, and known risk factors.
- Develop or import specific legal and clinical guidelines based on current literature that provide clear directives to all ED practitioners about:
  - How and to whom to make the *immediate* report suspicious injuries
  - When and whom to consult for greater expertise
  - What types of medical screening, testing and follow-up to order.
- Enforce a policy of immediate notice (on-site or by pager) to child abuse specialist and/or SCAN team for all unexplained or suspicious injuries in children.
- Have available contact information for local or regional experts of particular pediatric forensics or other subspecialties.
- Develop contacts with law enforcement or CPS for immediate reports of suspicious injuries and to check if child or caregivers have prior involvement in child protection system.

Screening of Injury Cases Not Presenting in Emergency Department:

- Establish a system to have medical practitioners in general pediatrics wards, even intensive care units, regularly contact child abuse specialist and/or SCAN team for any suspicious injuries or medical conditions may suggest child abuse or neglect.
- Develop a system for regular screening of hospitalized children in non-acute settings by child abuse experts or SCAN team members.

Reviewing Severe Nonfatal Injury Cases [See Section 2 of *The Guidelines* for more detail.]6

- Review describes the evaluation of one or more case by in-house experienced medical or social services staff. They might also include outside or collateral medical experts and/or non-medical community professionals.
- The purpose is to address a variety of concerns (e.g., expanding on-going SCAN consultations, re-examining problematic cases, responding to quality assurance questions, collecting data for research, and/or developing training topics).
- Schedule should be weekly for medical facilities offering maximum pediatric services; monthly or quarterly reviews for those facilities with moderate or minimum pediatric services.

Setting Up Hospital-based Review Teams

- California Penal Code 11167.5(b)(7) defines a "hospital scan team" as a team of three or more persons established by a hospital, or two or more hospitals in the same county, consisting of health care professionals and representatives of law enforcement and child protective services, the members of which are engaged in the identification of child abuse.
- Not all medical facilities will be able to support a large team with many outside members.
- Each medical facility providing pediatric services should set up a team that best fits its needs and capacity.
- Having more than one hospital in a region participate can be instructive provided appropriate confidentiality measures are taken.

Basic Considerations in Building a Review Process

- What will the main purpose be: investigation, medical quality insurance or assessment?
- How will cases be selected for review?
- Will the team review reported cases of suspected inflicted injury, any case fitting the profile for high risk injuries, or a combination?
- Will it be anchored in a particular hospital department with dedicated staff or will it be an assembly of experienced staff through the hospital?
- Will there be a partnership with hospitals providing more extensive pediatric trauma services?
- Who will coordinate the team? Who will appoint and oversee the members?
- Will the team be a full SCAN team with representatives from local police and CPS agencies or partial team with established contacts with police and CPS?
- Will the team have established relationships with pediatric specialists who regularly attend the reviews or who attend only upon invitation?
- Will the team participate regularly in any larger community based multi-agency review team?
- Will the team be expected to publish reports or only keep internal records?

Surveillance of Severe Nonfatal Injuries within a Hospital

Surveying Severe Nonfatal Injuries in Medical Settings

- *Surveillance* describes an on-going, systematic collection, analysis, interpretation and dissemination of data regarding the incidence and prevalence of serious nonfatal child injuries.
- Surveillance activities can be more or less elaborate and time consuming.
- Even simple surveillance projects can be used for quality assurance, risk management, systems improvements, research projects, or advocacy and prevention strategies.
- Nonfatal injury surveillance projects at one hospital could be compared with the observations made by other local, regional or statewide surveillance systems.
- Hospitals offering maximum pediatric trauma services are more likely have the capacity to conduct a surveillance project.
- Hospital initiated surveillance projects lay the groundwork for larger regional or community severe nonfatal injury reviews to share lessons learned and/or inform child abuse or injury prevention campaigns.

Some Considerations for Hospital-based Surveillance Programs

- Choosing a hospital department or individual to oversee or coordinate the program
- Determining data elements and reconciling them with those used in community, state, or outside agency databases
- Finding how to access databases to be used
- Deciding if only aggregate data, review of specific patient records or chart, or a combination will be use.
- Preparing to maintain patient confidentiality
- Working with Internal Review Board about possibility of missed cases that were not previously reported
- Deciding how findings and outcomes may be shared with other hospitals or agencies

The Central Role of Pediatric Hospitals Regional Child Protection Networks

Information Sharing

- The biggest obstacle is misunderstanding or misapplication of the legal protection of privacy, most notably HIPAA, but also corresponding state statutes as well.
- Sharing information by professionals in the course of reporting, investigating and assessing suspected child abuse is an exception to HIPAA and other state laws on privilege and confidentiality.
- Attempts for information sharing are further confused by the number of individual state and federal statutes as well as the policies of individual medical facilities.
- A summary of California and relevant U.S. laws was compiled for *The Guidelines* and can be found in the Appendix for easier reference. The summary is divided into sections for each profession: medical, law enforcement, child protection and so forth.
- Basic best practice, however, recommends each professional and each agency develop informal and formal relationships with professionals from other local agencies. A contact person can often facilitate the request for information by guiding the requesting agent through the bureaucratic barriers.

Developing Networks

Informal Networking

- Basic best practice recommends that each practitioner maintain professional relationships with representatives from other agencies that they have worked with in the past.
- The contact person can often facilitate the request for information by guiding the requesting agent through the bureaucratic barriers.

Cross-agency Networking

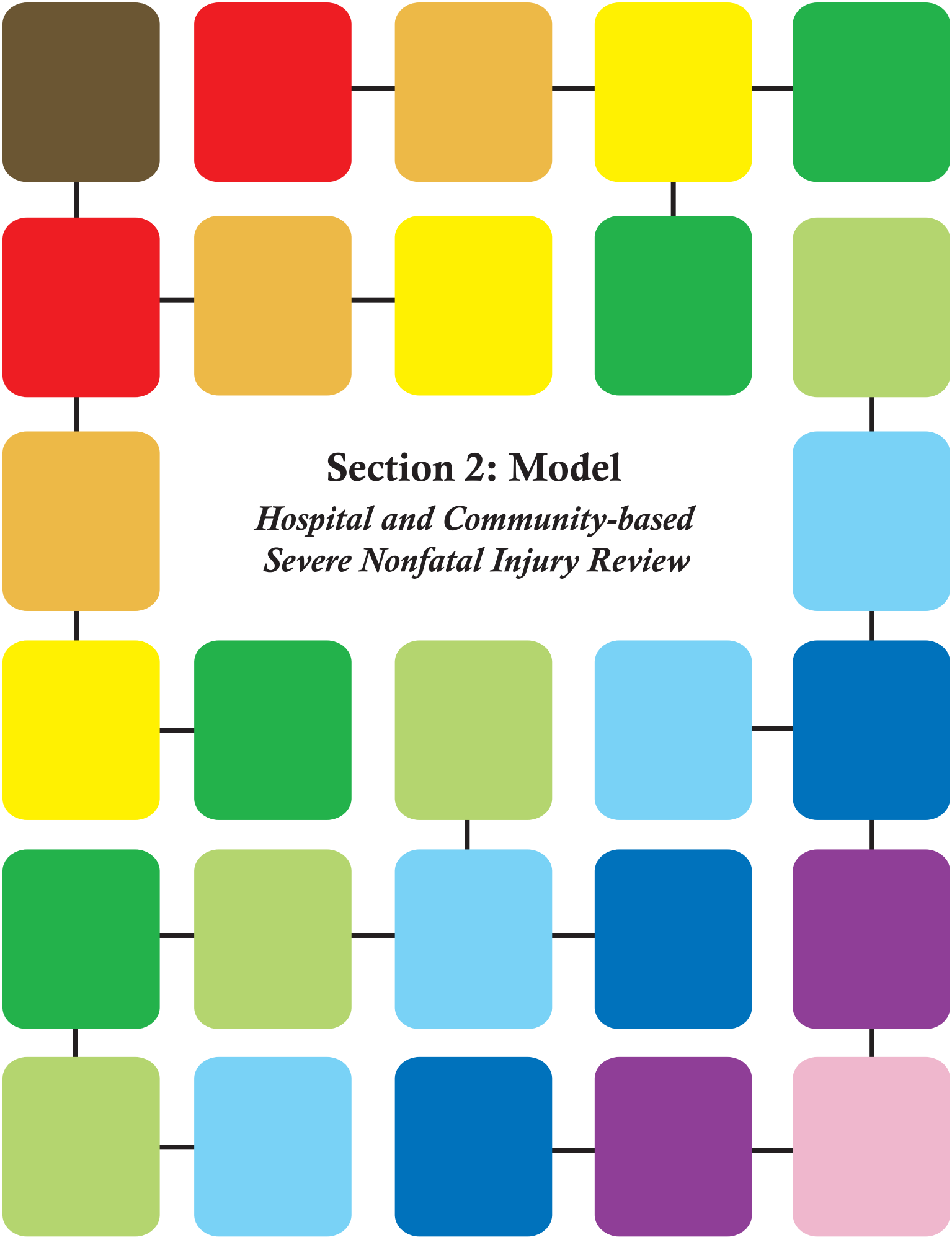
- Each medical facility should maintain formal relationships with other local and regional hospitals providing pediatric services, as well as community agencies involved in child abuse investigation or social services.
- A specific department, or SCAN coordinator, should be designated to maintain an updated contact list of other hospitals, pediatric specialists, forensic experts, police departments, and child protective services offices.
- Email distribution or Listservs of local professionals should be developed and used for consultation, training and conference announcements, and other related communication.
- Video conferencing capabilities can be developed for more immediate consultation needs when face-to-face meetings are not possible.
- Periodic cross-training or review meetings should be arranged to encourage a more familiar professional connection.

Community and Regional Networking

- Participate on regional child fatality or nonfatal review teams.
- Participate on local multi-disciplinary work groups to reviewing and recommending policy changes and/or prevention intervention campaigns.
- Development of cross-agency databases to share information on previous risks for child abuse that can be accessed by appropriate professionals in hospitals or community agencies working in the treatment or investigation of child abuse.
- Example of shared database: The Family & Child Index (FCI)

  Developed in Los Angeles County, the FCI regularly collects specific information about prior involvement from various departments: Public Health, Department of Children and Family Services, Los Angeles Sheriff's Department, Department of Public Social Services, Department of Mental Health, Probation, Offices of the District Attorney.

  Agents from any of these agencies can query the database by name of child or parent, date of birth, address to find if that particular child, parent, or address has had contact with any other agency in the past. Specific information on past child abuse is obtained after calling the listed contact person and a third investigating professional. The three-way conversation constitutes a multidisciplinary investigation team allowing the legal sharing of information.



Section 2: Model

Hospital and Community-based Severe Nonfatal Injury Review

Model for Hospital and Community-based Severe Nonfatal Injury Review

Purpose of Severe Nonfatal Child Injury Review

Most fatal and severe nonfatal child injury occurs in children under the age of five. Over 7,000 of these children are hospitalized each year in California.

By extending the systematic review of child fatalities to include severe nonfatal injuries, the professional's understanding of child abuse will be greatly enriched through closer examination of the medical, environmental and systemic characteristics presented. Specifically, the retrospective review of severe nonfatal injuries spotlights the medical system and how it approaches the identification, reporting and prevention of child abuse.

The systematic multi-agency review process suggested here should not be confused with an immediate hospital SCAN evaluation of a specific child's injuries upon admission to an emergency department or pediatric intensive care unit. Rather, it is suggested that the hospital, county or region develop a multi-disciplinary review process that focuses on specific areas for policy improvement and child abuse prevention that may not otherwise be captured in reviews of child fatalities.

Implementing a Severe Nonfatal Child Injury Review

Recommended Organization:

Severe nonfatal injuries greatly outnumber fatalities. This means not all injury cases can be conveniently or easily reviewed and that a sorting out process may be necessary. One solution is a two-tiered review process. The first tier would include hospital reviews of the severe injury cases within their own facility. From these hospital-based reviews, the most difficult, instructive or concerning cases would be referred to a community team for the second tier of review.

Of course, each hospital, county or region would design a system that works best for their needs. For example, smaller counties or rural areas with only one hospital providing pediatric trauma services might not require a tiered system. One review process may be sufficient. In that case, the hospital receiving the majority of pediatric cases in the region could house or organize a community multi-agency team to review the severe nonfatal injury cases. For best practices, medical practitioners experienced in child abuse should be *at the center* of any multi-agency team.

Whether a community opts for a one or two-tiered approach, the overarching goal in setting up hospital-based nonfatal review teams is to create a strong network of professionals with expertise in child abuse. Pediatric Trauma Centers and Children's Hospitals are the optimal lead agencies for setting up and participating in such review teams. They are most likely to see the majority of severe injuries in any region.

Other hospitals that are approved for pediatric emergency services or intensive care should also be encouraged to organize nonfatal review teams. As a hospital begins the review process, it is recommended that they establish links with other hospitals, in particular pediatric trauma centers or Children's Hospital Centers of Excellence, to share findings and discuss problems. Once this network has been developed, it becomes the driving force in creating a workable system that will

improve the detection of physical abuse and treatments of severe injuries in children. It then will be important to share lessons learned, models and resources. The multi-agency community-based (or second tier) review teams might also choose to develop networks with other regions or counties through their statewide or regional Child Death Review Teams. Making the decision to work closely with a CDRT could streamline the process of doing nonfatal reviews by using participants and venues already engaged in the process. More importantly since the findings of both types of reviews are likely to dovetail, collaborating on annual reports or coordinating the publication of outcome data might result more relevant recommendations or system changes.

Many of the considerations and organizational strategies for setting up a nonfatal review team are similar to those already described for CDRTs. Referencing those sources is also strongly recommended.[108, 111, 112, 113]

Goals:

The primary goal of the formal retrospective reviews described above is the prevention of abuse or injury. However, a team can elect to augment it with other objectives, such as:

- Develop child advocacy or prevention campaigns
- Collect data used to promote policy / protocol planning
- Publish reports for public education
- Track cases for feedback for quality assurance, service delivery, or risk management
- Train professionals within and across disciplines
- Design research projects

A review system should be organized that allows a medical facility to set goals for itself, or to collaborate with other facilities/agencies in joint reviews, or even to participate in a larger regional review team with broader goals. Each of these processes could have separate or related goals.

Implementing Severe Nonfatal Child Injury Reviews

Special Challenges for a Severe Nonfatal Injury Review

Funding and Agency Support:

As with all activities that are beyond the routine scope of service delivery, finding the time, funding and administrative support can be challenging. However, medical facilities, especially Children's Hospitals and/or designated Level I Pediatric Trauma Centers, should have severe nonfatal injury review programs. Both types of medical facilities are in a position to act as leaders in their communities in this area of child maltreatment. Both types of facilities understand the long term impact on the improvement of medical quality assurance and risk management and are best able to advocate, if necessary, for such review activities.

Identifying Team Members:

The team members must comply with the legal definition for hospital SCAN teams and multi-disciplinary child abuse teams. [75,96]

The initial phases of a hospital-based review, however, can be done with very few hospital staff members. Ideally, the team would include the hospital SCAN team physician, nurse and social services staff. If there is no formal SCAN team, the designated physicians, nurses or social services staff who are either trained in child abuse or who oversee the hospital child abuse reporting protocol, initiate this review process.

As the process continues, other hospital staff might include representatives from injury prevention units, the hospital medical quality assurance division, or medical subspecialties (e.g., emergency department, trauma surgery, radiology, ophthalmology, orthopedics, or mental health).

Representatives from community agencies should be included as soon as it is practical. Liaisons from law enforcement and CPS are both necessary. It is strongly suggested that team members sign agreements of collaboration so that the responsibilities and duties of each agency are clearly outlined.

Confidentiality and Information Sharing:

Sharing information about a child's medical condition in a severe injury review should not present a problem. However, when a child is alive and under the custody of his or her parents, disclosure of facts about the child's medical condition and treatment may be confusing to some professionals. This is particularly true of hospital administrators who may focus on HIPAA restrictions to sharing medical records. In actuality, child abuse is an exception to HIPAA which defers to each state to outline the specifics of information sharing regarding suspected abuse.

California law allows, though does not require, information on suspected child abuse to be disclosed to multidisciplinary personnel teams and hospital SCAN teams. Both types of teams must consist of three or more trained persons who are engaged in the identification of child abuse or neglect (e.g., health care professionals and representatives of law enforcement and child protective services). The shared information must, however, remain confidential within the team unless otherwise required by law to be disclosed. [75,77,96,113]

Mandated Reporting:

In California both the statute requiring all mandated reporters to report suspected child abuse/neglect, and the statute requiring medical professionals to report abusive or assaultive injuries, require an immediate report. Waiting for a final diagnosis before calling in a report to the child protective agency is a violation of the law. [95,96]

During a severe injury review, a case may be discussed that was not previously reported but which, upon review, appears to have been the result of abuse. A mandatory report will then need to be made. Any severe child injury review team will have to prepare for such an eventuality. The impact of a delayed report on the child, the family, the hospital, and the investigation may be problematic. Working out strategies for handling such a delayed report will be very important. For example, hospital quality assurance or internal review boards may need to be consulted before any reviews are undertaken by the team so they can establish a protocol before a delayed report is required.

Intake Screening of Cases:

Since there are many more cases of severe injuries than fatalities, each review team will need to establish a clear case intake process to decide which cases to review. For example, how will cases be selected or even come to the attention of the review team? Each team will need to determine how cases are chosen and which types of injuries are focused on at any given time. By necessity, some cases will be screened out. However, once the review process moves forward, the focus will likely evolve and change, steadily building upon lessons learned and other observations. It should be a dynamic process. A recommended start up approach is outlined in detail below.

Getting Started: Medical Settings

The Guidelines suggests a three-phase model. Each phase allows a hospital team to focus systematically on more specific injury characteristics so that they can chose the ones that appear to be of most interest at any particular time to their agency or community.

- Phase 1 is a simple task. By matching age groups of injured children for a specific time frame with the child abuse/neglect reports made during the same time frame, the hospital can establish a crude but helpful baseline of child abuse recognition and reporting. It can point the team to cases for further review.
- Phase 2 suggests a way to reduce the number of cases for review even further.
- Phase 3 extends the review to include other agencies for a more in-depth review.
- Phase 4 encourages participation in community multi-disciplinary reviews.

Phase I: Setting a Baseline

The first phase sets up the baseline of percentages of cases of severe injury that resulted in child abuse reports. The simple table (below) demonstrates the ability to recover the medical and child abuse data necessary for screening. Other factors may be added including death or other factors already collected. The process should generally fit with present resources**.** This phase could be done by any hospital with or without a formal child protection team or expert personnel.

- Locate hospital discharge records and child abuse neglect (CA/N) reports. Find someone from hospital records or data managers to help explain and obtain these record systems. Distinguishing cases that were transported from other hospitals is an important step.
- Screen for children under age five hospitalized during a specific period of time for injury with any of ICD-9-CM Codes. For smaller numbers focus on infants.
- Match the injured children to your child abuse/neglect reports. Create a spreadsheet like the example below. (See below: the numbers are contrived for example only.)
- Cases not reported are potential cases to review.

Baseline Percentage of Child Abuse/Neglect Reports for 2007*					
Age in Years	Number Children Hospitalized for Injury	Number Reported as Possible CA/N	Number Reported by Referring Hospital	Total Number of Children Reported	***Total Number of Children Not Reported***
0	12	2	1	3	***9***
1	15	1	0	0	***14***
2	8	1	0	0	***7***
3	6	0	0	0	***6***
4	1	0	0	0	***1***
Totals:	***42***	***4***	***1***	***3***	***37 to review***

**This table with contrived data demonstrates the first task.*

Phase II: Choosing Parameters & Screening

This phase requires some expertise with evaluation of possible abuse and neglect. To reduce the number of cases to be reviewed to a more manageable set, it might be advisable to select specific injury characteristics. This could be approached in many ways depending upon the interest, resources or needs of a particular hospital. This requires more specific matching of different data elements and/or using different data systems such as the ICD-9-CM or CDC Uniform Definitions of Child Maltreatment. [See Appendix: "Sample Hospital Spreadsheet" and "Index to External Causes-E Codes"]

The basic process is:

- Select from Phase I the cases not reported to get a smaller number for review.
- Screen cases for further reduction:
  - Remove cases that appear to be clearly non-inflicted, such as motor vehicle collisions;
  - Keep cases that appear as possible abuse, such as unexplained subdural hemorrhages.
- Conduct a chart review of selected cases.
- Identify any systemic or medical issue for change or training and implement.
- Select any cases appropriate for possible hospital SCAN or community team review.

Phase III: Reviewing Selected Cases

- Conduct an in-hospital SCAN review or Medical Quality Assurance Review.
- Refer cases to a community multi-agency review team.

- Document lessons learned or system problems.
- Collect data reports.
- Participate in any initiatives or activities for system improvement or prevention programs.

Getting Started: Community Multi-agency Severe Nonfatal Injury Review Team

Community-based nonfatal injury review teams should develop as a natural extension of local hospital-based review teams. As hospital teams collaborate, they can invite representatives from other community agencies to create a comprehensive multi-agency review team that will address broader issues of child maltreatment and prevention. [108, 111, 112, 113] Organizational decisions and actions would include:

- Have a Pediatric Trauma Center or Children's Hospital coordinate join reviews with other interested hospitals in the community or county.
- Add representatives from the relevant agencies: emergency medical services, law enforcement, prosecution, CPS, criminal and juvenile courts, mental health, public health, public social services, or others involved in child abuse investigation, treatment or prevention.
- Evaluate what funding sources are available such as participating agency in-kind services, existing community public health or child protection resources, or eligibility for private or public grants.
- Consider coordinating with the local Child Death Review Team to conserve resources and staffing.
- Determine a mission or focus of the Severe Nonfatal Review Team.
- Construct and implement a Severe Nonfatal Child Injury Review Team inter-agency agreement. [See Appendix: "Sample Collaborative Agreement"]
    - Acknowledge shared interest in establishing a multi-agency team
    - State commitment to effective child abuse investigation and injury prevention
    - Set down responsibilities for each agency
    - Delineate the rules for confidentiality and mandated reporting
- Decide if the team will produce any reports, collect specific data, engage public awareness campaigns or child abuse prevention initiatives, or any other project conduct.

Continuing the Process

Building on Previous Findings in Medical Settings

This three-phase model is intended to promote a continuous loop. Observations made or lessons learned during one of the phases can be used to design the focus for the next screening or review activity. The goal is to have an ongoing process that improves child abuse detection, treatment and prevention in any medical facility.

The process can be as simple or as in-depth as needed. The participants can meet annually, quarterly, or monthly. Not all hospitals will have the ability or resources to do extensive reviews or data collection. Although more detailed or extensive screening or review activities are encouraged,

they are not always necessary. Simply monitoring the relationship between the number of children hospitalized for injuries and the number of child abuse reports made on an annual basis (Phase I) can improve overall awareness and performance.

Handling Special Cases

Most cases should be resolved within the hospital or with a referral to a hospital Multi-Disciplinary SCAN Team. However, some cases will need additional resources. These would include cases involving multi-jurisdictions or complex medical issues or hospital deaths that might be then managed by the local Child Death Review Team.

Finding a Wider Audience

The strength of this model is a commitment to reach out to a broader audience of medical professionals and outside community members on issues of child abuse detection and prevention.

A hospital can choose to keep the review of severe nonfatal injuries within its own facility. However extending the discussion of traumatic injuries to other professionals can be a powerful mechanism to improving community and professional knowledge about child abuse recognition and investigation.

The data collected, observations made and lessons learned at one hospital should be shared with others.[108,110,111,112,113] There are many possible ways to do this:

- Organize periodic joint reviews with other hospital-based teams.
- Invite smaller medical facilities or private practitioners to attend reviews on shared patients.
- Conduct in-service training for medical and social services staff providing pediatric care.
- Work with hospital medical quality assurance or risk management for system improvements.
- Encourage cross-training opportunities with community agencies.
- Publish outcomes and findings of review.
- Establish a network for consultation for acute and non-acute cases.
- Participate in community-based severe nonfatal injury review teams.
- Initiate prevention or advocacy programs.
- Advocate for addition or changes in policy and legislation.
- Design and conduct data collection and community child abuse surveillance projects that can be used to supplement injury prevention projects, help unify or coordinate child abuse databases, or support research or policy change efforts.

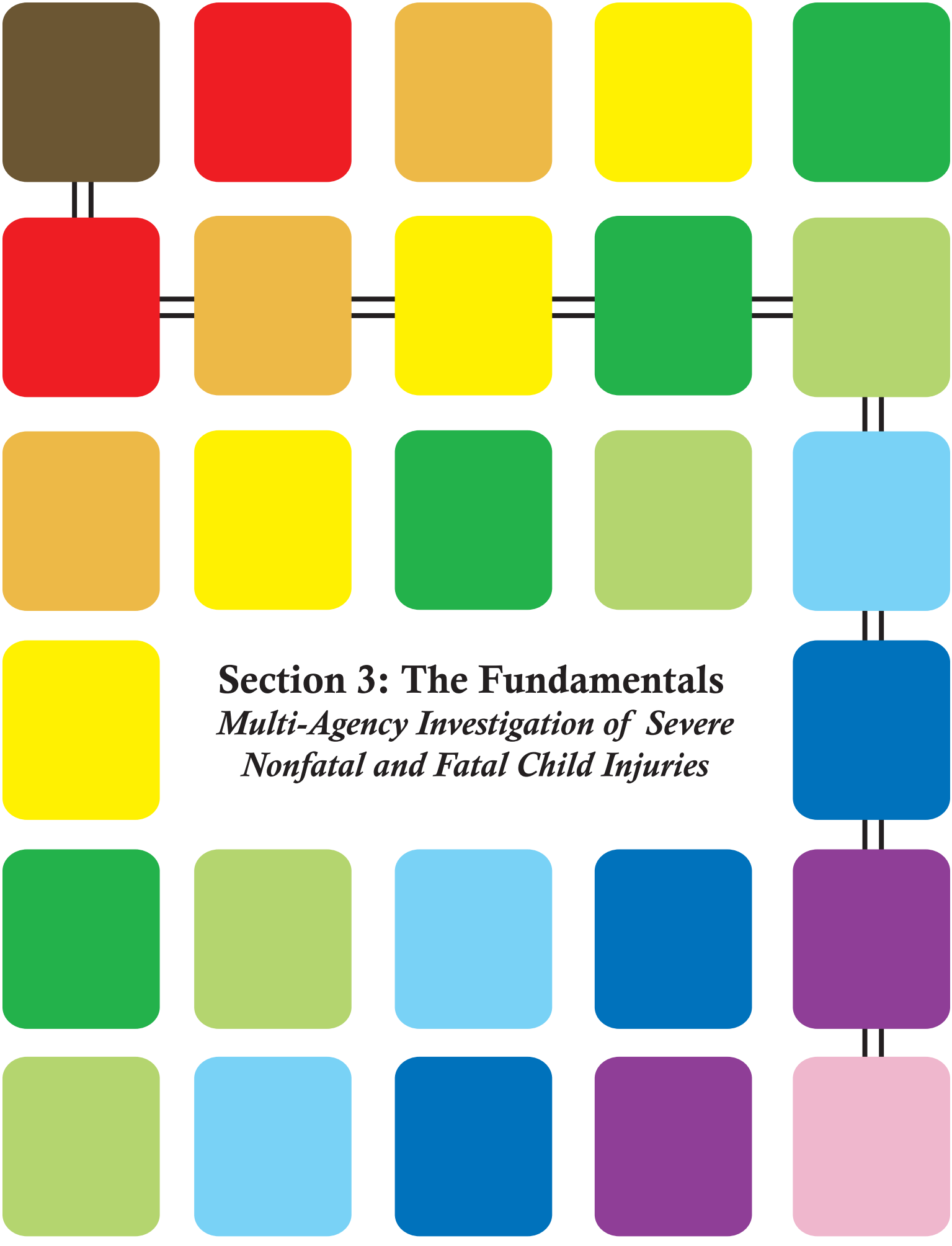
Not all review teams will have the capacity to undertake all of the activities discussed in this section. Funding, size and support will determine much of what is done with the data collected.

The major focus and outreach of this program is meant to be for hospitals with major inpatient pediatric trauma services. This includes Level One Pediatric Trauma Centers, major hospitals with a Pediatric Intensive Care Units, and major pediatric burn centers.

Some other hospitals may be added, but most general hospitals will be reached indirectly through the service network that pediatric trauma program provides to other medical facilities in their service area.

Additional indirect connections are also expected locally with outpatient programs including emergency departments. Links will be encouraged between hospitals and local child death review teams for children that die while under hospital care. The long-term expansion, including connections to national resources, is planned but will extend beyond the time and tasks outlined in this grant.[108,109,111,112,113]

The following section (Section 3) is designed to stand alone for multi-disciplinary training purposes and for easy reference. It will be available in a 'pocket sized' version in 2009. Please contact Lidia Escobar at (626) 455-4585 or manetla@dcfs.lacounty.gov for information and availability.



Section 3: The Fundamentals

Multi-Agency Investigation of Severe Nonfatal and Fatal Child Injuries

The Fundamentals of Multi-Agency Investigation of Severe nonfatal and Fatal Child Injuries

Training and Field Guide for Multi-agency Investigations

Understanding the fundamental principles of multi-agency child abuse investigation is crucial to a strong severe nonfatal and fatal injury identification and review.

This section of *The Guidelines* distills these fundamental principles into a ten-step field guide and training tool aimed at professionals who are new to child abuse investigation or new to a multi-agency team. More seasoned professionals, however, may find it useful as a reference guide to the challenges that emerge in collaborative investigations.

These ten fundamentals can stand alone from the other sections of *The Guidelines*. They are organized by content and are not strictly chronological. All of them, or parts of them, can be reproduced in a smaller format for ease of reference or training

This section can serve as the framework for inter- or intra-agency training curricula or accompany orientation materials for a multi-disciplinary team. These fundamentals are meant to supplement and not replace the detailed protocols developed by each discipline. They are also not meant as a guide to forming a multi-disciplinary team.

The ten fundamental steps are:

1. FOLLOW THE GROUND RULES: A Best Practice Approach
2. UNDERSTAND THE SYSTEM: Basic Duties of Investigative/Assessment Agencies
3. WATCH OUT FOR PITFALLS: Obstacle or Team Player?
4. ACTIVATE A TEAM: Necessity of Collaboration
5. GO TO THE SCENE: Preservation and Collection of Evidence
6. RECONSTRUCT THE SEQUENCE OF EVENTS: Interviews, History & Data Bases
7. COLLECT EVIDENCE: Power of Details, Photos & Measurement
8. MAXIMIZE INFORMATION SHARING: Key to Effective Investigation
9. SUPPORT VICTIMS AND FAMILY: Initial Assistance and Services
10. STAY CONNECTED: Building Relationships for Future Cases

1. FOLLOW THE GROUND RULES: A Best Practice Approach

Expected Behaviors for Collaboration

In any child abuse case, thinking and working collaboratively is a part of every professional's understanding, training and practice.[27,106, 107, 108]

Collaborate, Consult and Share

- You are part of a team, even if you are not assigned to one. If your jurisdiction does not have a pre-existing multidisciplinary team or center, it is the responsibility of every professional to link with other agencies and/or consultants as soon as possible.[8,17,23,27,29,39,41,45,46,48,56,78, 104,106,107,108]
- Never assume someone else is going to handle a particular step or function. Direct communication between team members is critical to coordinate each person's actions and support each others work.
- Be cautious, however, about making multiple calls and having multiple professionals and agencies burdened by crisscrossing and confusing calls. For example, try to talk to the most senior person responsible for the child's case.
- Don't interfere with another agency's performance of their duties. Communicate within and between agencies to address any differences or conflicts.[27,29,39,40,41,45,46,63,78]
- Consult within your own agency or profession as well for optimal input.[8,29,40,41,55,]

Build Rapport

- Take time to establish rapport and maintain a non-judgmental demeanor.

Show Respect

- Whether it is the other professionals, the family, witnesses or the suspect, the best results are accomplished by maintaining a sense of dignity and respect for everyone. Maintain family and agency privacy whenever possible.

Maintain a Balance

- The need to gather information and evidence should also take into account the emotional difficulty for the family including surviving children such as setting up an autopsy or going through a risky medical procedure.

Explain the Process

- Helping other professionals and the family understand what your role is and what the next steps will be can temper future conflict. Be careful, however, not to discuss details that might interfere with the assessment or investigation. For example, providing the family medical information on how the injury "might" have occurred so that the family changes its statement on how the injury happened.

Timeliness of Reporting and Consultation

Report suspicious injuries immediately:

- Call as soon as there is reasonable suspicion of child maltreatment; waiting for a diagnosis delays the process. [1,86]
- Dual reports to law enforcement and CPS are best practice for medical professionals [2,16,17,135]
- Send in the written Suspected Child Abuse Report (SCAR) later as directed.
- Notify the Office of the Coroner as soon as a child dies; consider having an agreement with the Coroner's Office to call once death appears imminent.

Cross-report the case immediately:

- CPS and law enforcement investigators must contact the other agency immediately. [1,15,36,40,55,]

Consult specialists as soon as possible:

- Contact experts in your discipline if you do not have specialized training (e.g., Juvenile crime detectives, SCAN or trauma physicians)
- Contact experts from other professionals including outside agencies (e.g., local Child Advocacy Center forensic interviewers, Pediatric Trauma Center SCAN physicians)

Document notes in a timely manner:

- Write thorough, consistent and legible entries. [29]
- Check with the child abuse experts in your agency to make sure your notes reflect an accurate account of the facts.

Key Attitudes for Assessment and Investigation

Personal Values:

- Watch your own bias. Such beliefs as "the system always inflicts more trauma than protection" or "it is ineffectual" can interfere with your ability to carry out your reporting duty or collect evidence objectively.
- Be cautious of stereotypes of race, gender, ethnicity, age, orientation, legal or socio-economic status as well as generalizations of how child victims, child abusers, or non-offending parents will look, act, or speak.
- Guard against emotional reactions that may result in colluding with the child, family member or others in not cooperating with the assessment or investigation.

Professional Ethics and Practices:

- Realize that professionals from each discipline bring their own specialized knowledge about children, injuries, assessments and/or investigations. Be open to hearing all points of view.

- Communicate carefully to minimize misunderstandings. Professionals from different disciplines need to take the time to explain things clearly to one another and be comfortable asking for clarification—about the case and about the process itself.
- Seek out assistance for job burn out, stress or fatigue that might impair ability to perform.
- Get peer support to work through any fears about negative outcomes in a case (e.g., retaliation, public criticism, legal action, loss of patient).

Cautious Reasoning:

- Analyze and assess the specific evidence you have.
- Don't fill in information or assume details that haven't been established.
- Don't jump to hasty, and often, incorrect conclusions.
- Don't stubbornly hold on to a view of the case without corroborating evidence

Inquisitiveness and Persistence:

- Follow up and pursue evidence that is incomplete, missing or lacks validation.
- Consult and collaborate to ensure all aspects of the case have been covered.

Respect for Scene of Injury/Death Protection [17,19,38,63,69]

The scene needs to be part of the consciousness of all professionals involved.

- It is where the child died, was injured, or first observed to be injured or dead. It could include the hospital room where a child died.
- The basics of scene protection are to preserve life, safety and evidence.
- For suspected crimes of homicide or child abuse, law enforcement takes the lead and maintains control of the scene or scenes. [69]
- When no crime is suspected, the Coroner's Office maintains control of the death scene for unexpected or unexplained deaths.
- Besides law enforcement and the coroner EMS and CPS may have duties at the scene.
- Any disturbance of the scene/s can alter the facts and result in a loss of evidence. Avoid contamination with unnecessary traffic.

Respect for Evidence Collection and Information Sharing

Know the lines of authority of an investigation:

- Which agency takes the lead,
- Who collects the measurements and documents the description of the scene,
- What other information has been collected by other professionals.

What facts can be shared with other professionals on the case and which cannot (e.g., certain serious crime details must be protected to maintain the integrity of the investigation, or certain mental health histories of a child or parent may need to remain confidential.

2. UNDERSTAND THE SYSTEM: Basic Duties

Shared Responsibilities:

Every discipline has a protocol which spells out specific mandates; however, all disciplines involved in the identification or investigation of suspicious child injuries/fatalities share certain responsibilities:

- Secure the safety and protection of the child to reduce future risk of injury
- Report suspected child abuse or neglect immediately to police or CPS
- Report all suspicious unexpected child deaths to police or CPS
- Maintain a multi-disciplinary perspective of consultation and collaboration
- Understand that any injured or deceased child is a potential victim of abuse or neglect
- Ascertain what happened and evaluate risks to others
- Provide support to the family as needed without jeopardizing the investigation

Basic Agency Duties:

Emergency Medical Services (EMS) and 911--Dispatch: [17,35,41,43,54]

- Dispatch the location of the injured child to EMS in a timely manner.
- Provide immediate medical intervention.
- Remain aware that an injured child is a potential crime victim.
- Report suspicious injuries or deaths to law enforcement or CPS.
- Balance critical emergency response services with collecting evidence that might be lost to later observers.
- Document all observations (photo or video document whenever possible). [54]
- Share documented information to relevant agencies (e.g., hospital, coroner, and police).
- Make an effort to explain the next steps of the process (without compromising investigation).

Medical Professionals: Physicians and Nurses [1,9,16,17,21,34,29,86,89,108]

- Save lives, provide acute and follow up treatment
- Stabilized the immediate injury and protect from future injury
- Report suspicious injuries or deaths to law enforcement or CPS.
- Establish history of events and medical conditions leading up to the death/injury [29]
- Consider possible risks in child's home or social environment [9]
- Consult with medical experts in child abuse and other specialists
- Collaborate with hospital social workers and any investigators (police, coroner or CPS)

Medical Professionals: Hospital Social Workers [2,17,30,41,]

- Monitor the child's and family's social needs and social network.
- Assist the child's family through medical assessment, treatment and discharge.
- Evaluate possible risks to the child and siblings in their home.
- Call in a report to CPS immediately upon suspicion of risk or abuse.
- Make service referrals for child and family.
- Interface with the medical staff physicians and nurses and any investigators (police, coroner, prosecutors or CPS). [2]

Medical Professionals Evaluating Severe Child Injuries [2,17,59,60,61,64,85,86,89,108,109,110]

- Recognize every injured or deceased child is a potential crime victim.
- Consider abuse and neglect in the differential diagnosis.
- Call in a report to law enforcement and CPS immediately upon suspicion. List the aspects of the case that caused the suspicion. Don't wait for final diagnosis of abuse.
- Evaluate the physical injury/condition of the child relative to current and past home environments.
- Attempt to determine the mechanism or conditions that caused the death/injury.
- Collect information from family, hospital staff, law enforcement and CPS. [17,60,61]
- Get a thorough medical and social history of the child.
- Maintain a primary focus on provision of care and balance it with assisting the investigation.
- Use child abuse medical experts as the *medical* liaisons to investigating agencies.
- Use social work staff to act as liaisons or contacts for investigating agencies.
- Centralize the documentation of diagnosis and findings on suspected child abuse cases with the SCAN coordinator or hospital child abuse expert to maintain consistency for collaboration with investigators and later court testimony.

Medical Professionals upon Child Death or Imminent Death: [9,21,62,65,192,68,108]

- Have an established protocol with the local Coroner's Office or Medical Examiner.
- Contact the coroner's office immediately at the child's death or near death.
- Balance support for the family with protection of evidence until the coroner arrives.
- Don't move the child's body.
- Don't remove tubes or connections to medical appliances.
- Avoid contact with the body as agreed with law enforcement or coroner. Limit loved ones' contact to only holding the child's hand or touching the child through a blanket.
- Don't begin tissue or organ harvesting before the approval of the coroner or other county protocol.

Medical Professionals: Helping the Child and Family [62]

- Inform the family on the child's condition and treatment plan.
- Give basic information on the next steps in treatment without interfering with the investigation and revealing details of the case.
- Determine family religious or cultural practices (e.g., time of burial or views of autopsy).

Coroner Investigators and Medical Examiners: [15,17,19,26,29,58,108]

- Take custody of the child's body at the scene unless a homicide is suspected. [19]
- Protect the body and collect evidence at the scene where the child died or was found. [19]
- Determine environmental hazards that could place others at risk. [19]
- Report suspicions of child abuse or neglect immediately to law enforcement and CPS. [15,19]
- Collaborate with law enforcement if a crime is suspected. [15]
- Collaborate with EMS and hospital medical staff when relevant.
- Determine the possible history of events leading up to the child's death.
- Consider the possible mechanism or conditions that caused the death or injury.
- Report observations of dangers in the child's home to law enforcement or CPS.
- Consider the preservation of evidence when:
  - Allowing family an opportunity for closure with the decedent, if appropriate,
  - Informing the family of the next steps (e.g., autopsy schedules, release of body).
- Be prepared to work with the cultural or religious practices surrounding treatment, autopsy and burial time frames.
- Perform autopsies. [26]
- Determine cause and manner of death.
- Decide when, and to whom, to release the body or allow harvesting of organs/tissue.

Criminal Justice System: Law Enforcement: [1,3,13,15,17,18,19,20,22,23,29,31,35,36,39,40,41,42,43,44,51,55,69,104,107,108]

- Distinguish the duties of responding patrol officers from detectives as outlined by individual agency protocols. [43,44]
- Investigate child fatalities and suspicious injuries of abuse or neglect.
- Cross-report all suspicious child injuries to CPS.
- Report all deaths to the Coroner's Office and CPS.
- Protect child, siblings, family and the community at large.
- Determine if a crime has been committed and present evidence to prosecutors.
- Control and preserve all scenes or locations relevant to the suspicious injury/death. [19, 20]
- Obtain appropriate search warrants—always the best practice.

- Consult and interview 911 Dispatchers, EMS, attending physicians, and forensic child abuse experts in cases of injury. Consult with medical examiners or coroner in fatalities to determine if the injury/fatality were accidental or non-accidental.
- Interview thoroughly informants/witnesses thoroughly and as soon as possible to lock in statements. [13,23,42]
- Interrogate suspects as directed by department protocol.
- Conduct a crime scene investigation. [53]
- Collect results of an expert medical examination or autopsy.
- Obtain medical history and current or prior child welfare involvement/records.
- Log, store and maintain the chain of custody for all evidence.
- Determine if protective custody is required under WIC 300a-j. CPS will determine placement. [18,22,122]
- Consult with prosecutors on serious cases if you are not trained in child abuse/homicide.
- Collaborate with CPS in arranging the protection of all children in the home and strategies for the investigation when appropriate.
- Write comprehensive reports on all non-accidental injuries or fatalities.
- Notify those in your agency responsible for the follow-up investigation in a timely manner.
- Remain objective and neutral while being sensitive to the family – who may be suspects – until the process is complete.

Criminal Justice System: Prosecution (District Attorneys, City Attorneys, US Attorneys): [4,5,8,15,18,86,49,53,58,60,104,107,108]

- Assist with consultation and obtaining of search warrants.
- Provide direction for law enforcement in determining filing options.
- Collaborate with the Coroner's Office for all unexpected/unexplained deaths.
- Interface with medical personnel (e.g., coordinating court, experts, or statements).
- Understand the limits for medical professionals and coroner investigators to conclude abuse or neglect beyond a reasonable doubt. [57]
- Present cases for trial and prosecute the deaths or injuries to children where abuse or neglect was involved per California state codes or other regulations.
- Work with victims, families, child abuse experts and law enforcement. [15]
- Interface with Juvenile Dependency Court or CPS on concurrent or prior cases. [58]

Child Welfare System: Child Protective Services [8,15,31,122,49,50,104,106,108]

- Cross-report all incidents of child injury or fatality immediately to law enforcement. [15]
- Determine best collaborative action—know whom to include:
    - Coordinate joint response with police to the injury scene and/or hospital;
    - Evaluate and arrange placement for all children taken into protective custody by law enforcement;
    - Consult with the coroner investigator (if relevant), attending physician, nurses, and hospital social workers.
- Coordinate with medical professionals and the police--working in isolation results in confusion and compromises the safety net for the child.
- Assess safety of child, siblings and family for alleged abuse or neglect.
- Conduct separate investigation of injury/death, if part of an agency-specific protocol; remembering that law enforcement takes the lead in investigation. [15]
- Assess family dynamics, risks, socio-economic stressors for safety.
- Provide reasonable efforts to remedy the risks in the child's home.
- Devise safety and/or case plans for child, sibling, and parents.
- Attempt to keep the child in the home of the non-offending parent.
- File a petition in Juvenile Dependency Court if child is placed outside the home.
- Assist parent in getting services to reunify with child unless otherwise court-ordered.
- Start planning for permanent home (reunification, adoption, legal guardianship).
- Link child and family to appropriate community services in a timely manner.
- Set up any necessary medical, mental health or academic evaluations.
- Collect and maintain child's medical, mental health and academic records.
- Cooperate with police and prosecution in criminal cases (e.g., sharing information, testifying in court, coordinating assess to child victim, act as liaison to Juvenile Court).
- Explain to child and family, as appropriate, the complicated child welfare and criminal justice systems.

Child Welfare System: Juvenile Dependency Court System (County Counsel) [8,15,22,31,122,53,57,77]

- Represent CPS in Juvenile Dependency Court in assessment and efforts to remedy risk to children in the homes of their parents or guardians through Family Maintenance, Reunification or Permanency case plans.
- Understand the limits for medical professionals and coroner investigators to conclude abuse or neglect without having had access to information or evidence on the child's medical history and events leading up to the injury even with a burden of proof at preponderance of evidence. [31,53,57]
- Interface with Criminal Justice system (e.g., police, prosecutors). [15]

Support Professionals (e.g., interpreters, domestic violence counselors, school personnel, Regional Center case managers, Child Life Specialists): [6,7,12,35,57,70]

- Focus on providing support services to, or advocacy for, the child or family members with special needs (e.g., disabilities, trauma, grief, mental health, linguistic, cultural, orientation or legal needs).
- Provide special skills or services to assist the investigators or medical professionals to perform their duties more effectively (e.g., translation, counseling, support) when appropriate.
- Inform other investigating professionals about legal restrictions such as confidentiality that would inhibit participation in an investigation. [57]
- Disclose to investigators from the beginning of the collaboration your personal or professional relationship with the child or family that might compromise or confound the investigation.

3. WATCH OUT FOR PITFALLS: Obstacle or Team Player?

Commitment to Collaboration:

Many obstacles present themselves during an investigation into suspected child abuse. Most can be overcome or the effects lessened. [27,37,104,105,107,108,110]

- Better specialized cross-training by agencies involved
- Stronger building of inter- and intra-agency relationships and networks

System-wide Obstacles

- Not calling law enforcement early enough in a case of child injury/fatality
- Not being able to get accurate medical and mental health records for children or adults in the case to assess danger adequately
- Providing evidence or details about the injury or investigation to family members that can be used to contrive an alibi or change the explanation of the injury
- Bureaucratic red tape that blocks timely access to legal authority for certain emergency medical treatment, search warrants, past medical records, or protective orders
- Failure to collect and document the interviews by 911 dispatchers, EMS, CPS or other professionals who have had contact with the child or the case
- Doing parallel and separate assessments or investigations without collaborating with the other agencies can undermine the quality of each assessment or investigation
- Having the children undergo unnecessary multiple interviews by different professionals
- Competing or conflicting legal time frames in criminal and juvenile court systems
- Lack of systematic notification to all agencies when a child victim or a suspect are concurrently involved with criminal, juvenile and/or family law court proceedings involving the injured child or other children in the care
- Not having agreed upon pathways to resolve disagreements among agencies
- Continual turnover of agency experts or personnel trained in the identification and investigation of child maltreatment
- Insufficient training within the ranks of all agencies about best practices in responding to incidents of child maltreatment or unexplained deaths [24]
- Lack of, or limited access to, trained forensic professionals in the community who are experienced in recognizing and responding to cases of child maltreatment
- Not knowing how to make direct contact with other agencies involved in the assessment or investigation or whom to contact or how they are organized
- Not maintaining a “healthy suspicion” after a death/injury
- Allowing personal beliefs and feelings to interfere with doing one’s job such as not producing thorough reports, providing only selective biased information, withholding certain facts and/or failing to consult and collaborate with experts in the field

Emergency Dispatch and EMS Responders - Obstacles

- Removing a dead child from the scene [17,108]
- Performing life saving interventions on a child that is already dead
- Not reporting suspicious injuries to law enforcement or CPS
- Giving family members and witnesses at the scene specific medical information about the child's injury before law enforcement or coroner arrives
- Advising or helping the family or individuals at the scene to tidy up or prepare for the arrival of law enforcement and/or coroner investigators

Coroner and Medical Examiners - Obstacles

- Not advising hospital staff on the best practices in preserving evidence when a child dies or when death is imminent prior to the actual arrival of the coroner investigator [10,108]
- Failing to explain clearly to investigative agencies reasons for decisions on manner or cause of death
- Not having uniform criteria for determining manner and causes of death
- Giving family members and witnesses at the scene specific medical information about the child's injury before law enforcement has interviewed them

Medical Professionals and Hospital Social Workers - Obstacles

- Not reporting suspicion soon enough to the authorities and losing physical evidence
- Providing too many medical details in the first call to the authorities about the on-going medical procedures for the differential diagnosis so that the non-medical professional is inadvertently confused into thinking no abuse is suspected
- Not controlling the family members' access to the child in the ER room when abuse is suspected (somewhat less problematic for a child in the Intensive Care Unit)
- Not protecting the body of a child from tampering by family or untrained staff in ER
- Using CPR or other resuscitative actions on a dead child to comfort the family
- Not completing toxicology screens in a timely manner or not at all
- Not notifying the Coroner at the first brain death announcement
- Not having, or not following, a protocol worked out with the coroner for preparation of tissue and organ donations in cases of unexpected or unexplained deaths
- Explaining to family and witnesses specific medical information on the status and mechanism of the child's injury causing them to contrive an alibi or change their story before law enforcement has interviewed them to lock in a statement
- Not centralizing the documentation of medical charts and findings with a child abuse expert or SCAN team member coordinator to control for accuracy and consistency when collaborating with investigators or later court testimony
- Not honoring criminal or dependency subpoenas in a timely manner

Criminal Justice System: Law Enforcement and Prosecution - Obstacles

- Deferring response to child abuse reports to CPS or accepting CPS assessment of a child abuse report without doing an independent police investigation
- Continuing a child abuse or fatality investigation without consulting an expert or having specialized training in child abuse
- Releasing the name of the mandated reporter to unauthorized individuals or family members
- Not being able to conduct a medical screening interview with people/family members needed for determining medical needs, conditions or mechanism of injury
- Having untrained patrol officers interview children instead of a more experienced detective or forensic interviewer [51]
- Taking children into protective custody without formally booking them and just letting CPS put them into placement
- Limiting or interfering with a doctor's ability to complete medical screening interviews with people/family members
- Giving family members and witnesses specific information from the investigation causing them to contrive an alibi or change their story before the investigating officer has locked in a statement
- Not providing feedback on the outcome of the case to other professionals who had reported or collaborated in the case

Child Welfare and Dependency Court System: CPS Workers and County Counsel - Obstacles

- Not finding out about other children (including newborns) under the custody of the suspected abusing parent
- Giving family members and witnesses specific information from the investigation causing them to contrive an alibi or change their story before law enforcement has interviewed them to lock in a statement
- Failure to examining scrupulously all in-home or relative placements as to whether or not the parent or relative may still be in denial of the risks posed by the suspect
- Not having sufficient training in forensic interviewing which leads to leading interviews that can contaminate the evidence and/or cause possible secondary trauma to the child
- Tipping off the suspect or suspect's family with too many explicit details of the investigation by conducting interviews or family conferences for CPS assessments and/or upcoming Dependency Court hearings
- Having to provide detailed information about the child's injury or death in Dependency Court while the criminal investigation is still taking place
- Explaining to family members and witnesses specific medical information on the status and possible mechanism of the child's injury before law enforcement has interviewed them to lock in a statement
- Failing to turn over case records to prosecutors for review per P.C. 827 or not honoring criminal court subpoenas in a timely manner

- Refusing to talk to prosecutors or testify in criminal court and not consulting with County Counsel
- Not providing feedback on the outcome of the case to other professionals who had reported or collaborated in the case

Support Service Professionals - Obstacles

- Interrupting or interfering with the interviews of the child, family members or other witnesses
- Not understanding the basic elements in child abuse and neglect assessment and investigation
- Providing details to the child or family members specific information from the investigation or medical assessment obtained while assisting the authorities or the family during the initial crisis causing them to contrive an alibi or change their story before law enforcement has interviewed them to lock in a statement

4. ACTIVATE A TEAM: Necessity of Collaboration

Basics of Multi-agency Coordination and Collaboration [27,78,104,106,107,108]

Within Medical Settings when Child Injury/Fatality is Suspicious: [2,85,86,89]

- Call immediately to report suspicious child injuries/fatalities to police, coroner, and CPS.
- Have an up-to-date list of hotline reporting numbers, and contacts for law enforcement agencies, CPS offices, coroner investigators.
- If your hospital/facility has an existing SCAN team, call them - use them or start communicating to organize a multi-disciplinary response.
- Contact the hospital social work unit.
- Consult with medical forensic and child abuse experts.
- Build relationships for collaboration with police, coroner, and CPS.

Investigation Teams for First Responders to Child Abuse or Neglect Reports: [17,25,41,108]

- Receive a report with allegations of child abuse or neglect.
- If your jurisdiction or agency has an existing multi-disciplinary team, call them or contact appropriate agencies to set up an investigation plan. [25,27]
- Cross-report to the appropriate agency (police or CPS).
- Know the appropriate agencies in areas with complicated jurisdictional boundaries, such as military bases, tribal reservations, or adjacent county sharing medical facilities.
- Speak to others directly to ensure effective response. Don't just leave a voicemail or email.
- Identify the lead agency for the investigation:
  - Law enforcement if the child injury or death is suspicious and potential crime,
  - Coroner's Office if the death is unexpected and child abuse is not suspected,
  - CPS when a child or other children appears to be at risk but there is no fatality or a crime of physical/sexual abuse or severe neglect is not yet suspected.

The Lead Agency Investigator:

- Contact the medical professional examining and treating the child.
- Organize a conjoint response for law enforcement and CPS if both are involved.
- Meet face-to-face with other professionals if practical, otherwise by telephone or video-conferencing.
- Exchange contact information, numbers, schedules, and other back up staff.
- Design a preliminary investigative plan that coordinates the actions of all relevant professionals who will be collaborating on the case. Update as needed.

- Clarify who needs what information and who will perform which duties:
  - Who will manage the scene? Is there more than one scene?
  - Who has the most experience in child abuse investigation?
  - Who has the most medical expertise in identification of child maltreatment?
  - What other agencies, experts or collaterals need to be contacted?
  - Who will need to be interviewed; who will do it, when and where?
  - How and by whom will medical history be collected?
  - How can prior criminal and CPS involvement be obtained?
  - How are special needs (e.g., language, culture, disability) determined?
  - How and by whom will evidence be collected, organized, and preserved to prevent duplication of efforts and confusion?
  - How will other collaborating agencies obtain evidence, or copies of it?
  - Are any special time-sensitive tests for the child, the parent and/or the suspect needed (e.g., drug/alcohol tests, acute forensic exams)?
  - Who will schedule the necessary exams?
  - Is protective custody in order? How many children are there?
  - Who will transport the children, caregiver or suspect if needed?
  - Are there any known limitations or barriers that will need to be addressed (e.g., special needs, linguistic or cultural concerns, legal status)?
  - How and when will future evidence and reports be shared?
- Have a current list of collateral contacts for local hospitals and medical facilities, medical child abuse experts, medical specialists, and other support professionals (e.g., interpreters, child life specialists, grief counselors, disability or special needs experts, child advocates).
- Identify the best contact person or division as well as the most senior or experienced person of an agency.
- Carry out the investigation plan, including any mandated protocols.
- Maintain contact with others working on the injured child's case as appropriate (i.e., the team).
- Identify and contact the prosecutors involved in the criminal filing, or the county counsel if a petition has been filed in juvenile dependency court.
- Continue communication with the investigation team as needed until all legal action has been completed.

5. GO TO THE SCENE: Preservation and Collection of Evidence

Establish the Scene (There may be more than one)

Possible Locations:

- Where the injury took place
- Where the medical condition or injury was first noticed
- Where the child's body was found
- Where the child died, including medical facilities

Search Warrants:

- If a crime is suspected, law enforcement should secure a search warrant whenever possible.
- A search warrant usually allows for only one entry. For later entry another warrant will be needed.
- If no crime is suspected, coroner investigators or medical examiners don't need a warrant.
- CPS will need to obtain a search warrant if the family refuses entry, unless there are exigent circumstances and law enforcement is also responding.

Establish the Lead Agency Responsible for Collecting Evidence

- Law enforcement – When the child injury or death is suspicious and a potential crime.
- Coroner's Office - When the death is unexpected and child abuse is not suspected.
- CPS - When a child or other children appear to be at risk, but there is no fatality or crime of physical/sexual abuse, or if severe neglect is not yet suspected.

Individual Agency Duties

Emergency Medical Services (EMS): [17,41,108]

- Observe and document basic evidence at the scene using measurements, photographs, medical findings, behaviors or statements of witnesses relating to the injury.
- Photograph area where child found and position child found, especially in serious "scoop and run" scenarios. [54]
- Contact law enforcement if abuse or neglect suspected.
- Move an injured child only to provide medical treatment, manage safety or transport.
- Note the location, position and condition of the child as found at the scene.
- Notify coroner's office immediately if child dies.
- Do not transport a dead child from the scene without direction from coroner's office.
- Share documented observations to law enforcement and/or ED staff.

Medical Professionals: [17,21,108]

- Unexpected or suspicious child fatality: Hospital becomes a scene. [65,192]
  - Notify coroner's office immediately once the child dies or death is imminent.
  - Do not allow until coroner investigator arrives: [17]
    - the movement of the body of a dead child,
    - anyone to be alone with child's body,
    - any direct contact with the body except holding the child's hand or touching of the child through a blanket,
    - any tubes or medical appliances to be removed from the child,
    - harvesting of organs or tissues.
- Suspicious child injury: Visiting the scene is optimal, if possible:
  - Visit scene of the injury with law enforcement.
  - Look for physical signs associated with injury.
  - Interview the family about the child's recent and past medical condition and records.
  - Share documented observations with law enforcement and CPS.

Law Enforcement: [33,39,40,43,44,55,69,10,107,108]

- Contact medical experts, treating doctors or coroner as soon as possible.
- Control the scene if a crime is suspected. Getting a search warrant is always best practice.
- Know what agencies should be represented for the investigation.
- Coordinate an investigation plan with collaborating responders at the scene - reassess as needed so that the tasks of each professional are clearly understood and organized.
- Secure the scene as soon as possible to prevent loss or disruption of evidence.
- Consult an experienced child abuse investigator if you lack specialized training, or contact a prosecutor for general information.
- Take all measurements and document and collect all scene evidence.
- Collect evidence relevant to the crime of physical or sexual abuse, and evidence that could be signs of the crimes of neglect or endangerment.
- Don't leave the scene before evidence collection is complete to prevent having to get another warrant later for re-entry.
- Preserve all evidence and information found at the scene.
- Log and document all evidence: observations, statements, actions, measurements, photographs, and physical conditions as soon as possible to ensure accuracy. [54]
- Share observations with medical experts to assist in establishing the mechanism of injury.
- Share documented preliminary and supplemental records with CPS and/or Juvenile Dependency Court if applicable. [55,57]

Medical Examiners and Coroner's Investigators: [39,98,40,54,108]

- Control the scene if a crime is *not* suspected and no search warrant is necessary.
- Preserve all evidence and information found at the scene.
- Log and document all evidence: observations, statements, actions, measurements, photographs, and physical conditions as soon as possible to ensure accuracy. [54]
- Use doll placement for photographs of area where, and in what position, the child was found. [54]
- Notify law enforcement or CPS as soon as a crime and/or abuse is suspected. [1]
- Share documented observations and records with law enforcement and/or CPS. [1,57]

Child Protective Services:

- Respond with law enforcement, if possible, or contact them immediately if physical/ sexual abuse or severe neglect is suspected.
- Consider contacting medical experts, treating doctors or coroner before going to the scene.
- Log and document all evidence: observations, statements, actions, measurements, photographs, and physical conditions as soon as possible to ensure accuracy.
- Share documented observations with law enforcement and prosecutors, medical professionals, and county counsel. [57]

Basics of Scene Preservation and Evidence Collection:

What <u>not</u> to do - Do Not:[17,69,107]

- Turn appliances off or on
- Use or flush toilets, sinks or tubs
- Step on any objects, if possible
- Clean up any spills, messes, dishes, laundry, bedding, etc
- Throw anything away
- Empty or remove any garbage or trash
- Change the clothes or diapers of a victim
- Let any witnesses leave until interviewed

What to do - Do:

- Assess for any immediate life-threatening danger
- Render any required medical aid (transport the injured child if needed)
- Protect all individuals (including the responders themselves) from any interpersonal or environmental dangers

- Maintain the scene with as little disturbance as possible until all evidence is recorded, seized and documented and all circumstances are reconstructed
- Identify who can come into which areas – minimize unnecessary access.
- Mark and communicate acceptable entrances and exits.
- Utilize protective clothing.
- Interview witnesses as soon as possible.
- Collect, document, measure and/or photograph physical evidence (e.g., clothing, bedding, water temperature, physical environment, distances, and heights).
- Determine if drug/alcohol or other specialized evidence collection is needed.

If time has elapsed:

- Consider that evidence has been lost or damaged.
- Record why the scene investigation was delayed.
- Contact hospital medical practitioners, CPS, child abuse experts or other collaborating agencies about what details they observed, collected and documented. [57]
- Consult with hospital medical practitioners, social workers, and child abuse experts about possible causes and/or mechanisms that could account for the child's injuries or about any suspected social or environmental problem in the child's life can be valuable. [57]

6. RECONSTRUCT THE SEQUENCE OF EVENTS: Interviews, History and Databases

Collecting Full Set of Facts

Time Frame and History

- Collect all background history: CPS, criminal, birth, medical, educational, developmental or mental health records of child. [22,53,107]
- Establish a basic but detailed chronology of actions surrounding the injury/death from the time the child last appeared to be 'normal.'
  - Who last saw the child alive and well?
  - Who first discovered the child's injury or condition?
  - When, where, what did they see, and what did they do?
  - Who called for assistance, when, how, and whom did they call?
  - Who else was present at that time?
  - Who routinely had contact with the child or provided care?
  - What food, drink or medications did the child ingest in the last 48 hours?
  - What were the child's sleeping patterns and practices?
  - What activities, daily routines, or incidents took place in last 48 hours?
  - What recent changes, milestones or unexpected behaviors have been observed?

Coordinate with Other Professionals and Agencies

- Seek complete reports from medical professionals, EMS, law enforcement, CPS.
- Decide who can best collect and manage the various pieces of information in order to decrease duplication of efforts and insure each professional gets the facts they need to complete their work.
- Get prior and current social information on child, siblings, and parents/guardians. [22,25,60,61]
- Consider collecting any 911 tapes.
- Get signed consents and releases of information as soon as possible.
- Consider video or audio-taping interviews and interrogations (as county protocols allow) and getting signed written statements from witnesses.
- Know legal restrictions and rights in getting medical, criminal or CPS records. [22,57,60,61,67]
- Follow established checklists/protocols when appropriate (e.g., CDC SUIDI investigations). [33,13,17,23,33,40,41,42,109,50,65,108,112]
- Determine how to share pertinent information with collaborating agency professionals in a timely manner within the legal requirement. [14,31,122,53,57,60,61]
- Clarify with all collaborating professionals which pieces of information are confidential and/or critical to the on-going investigation and not, therefore, released or reported without strict controls. [14,31,122,53,57,60,61]

Compile medical information:

- Collect current and past medical history from the caregiver – focus on prior injuries,[62] medical conditions, developmental history, hospital/location of birth.
- Ascertain what medical aid was administered by EMS or the family.
- Obtain contact information on physicians (e.g., treating, attending, experts), nurses and hospital social workers connected to the current injury or fatality.
- Obtain contacts for child's regular pediatricians and medical care specialists.
- Get birth records on young children or to determine total pregnancies and births .
- Consult with child's former physicians and medical care providers and specialists, especially in cases of suspected Pediatric Condition Falsification.
- Find out about the child and siblings—temperament, daily routines, behaviors, etc. [62]
- Consult with CPS to get other leads to past medical treatment or diagnoses. [60,61]
- Review local medical databases: e.g., Los Angeles County Trauma and Emergency Medical Information System (TEMIS). [72]

Compile CPS and Social Services Information:

- Document social background information and current case information. [60,61]
- California Child Welfare Services/Case Management System (CWS/CMS) for current or past CPS involvement.
- Local databases: e.g., Los Angeles County Family and Child Index (FCI),[25] Department of Mental Health, Community Care Licensing, Los Angeles Eligibility Automation Determination Evaluation and Reporting (LEADER). [73]
- Vital Statistics—birth/death records of other siblings or other child deaths in immediate family. [60,61]

Compile Criminal History Information:

- Department of Justice records: e.g., California Law Enforcement Telecommunications System (CLETS) and Child Abuse Central Index (CACI)
- Local police records and 911 logs and tapes

Interview informants, primary and collateral witnesses [42,106]

Setting Up Interviews:

- Make a list of informants, primary and collateral witnesses to interview.
- Conduct interviews as soon as practicably possible to lock in statements. [23,42,51]
- Work jointly with other professionals on interviews whenever possible to decrease miscommunications and witness inconsistency. [42,51]
- Separate witnesses for interviews and record their response in detail. [17,42]
- Try to recreate the scene as you record the statements in your narrative/report.

- Maintain the privacy of the family when talking in public spaces (e.g., hospital waiting rooms, in apartment complex).
- Find out about the child—temperament, daily routines, behaviors, etc.
- Get a history of family members, stressors, past violence, and the family's social network. [60]
- Consult professionals involved with the family: mental health practitioners; schools; special needs, disability or substance abuse counselors, etc.

Documentation:

- Document all statements as soon as possible to maintain accuracy and verify:
  - Who made the statement,
  - When and where they were interviewed,
  - What their relationship is to the child,
  - Where they can be contacted (e.g., work, home, cell, emergency contact numbers),
  - Where they can be found (e.g., work and home addresses, current and prior).
- Update and supplement the basic chronology as new facts are learned.
- Look for consistency or contradiction in the statements; follow up to clarify.

Collaboration:

- Communicate and exchange the findings with collaborating agencies as appropriate.
- Set up follow up or supplemental interviews where necessary.

7. COLLECT EVIDENCE: Power of Details, Photos & Measurement

Basics of Evidence Collection:

If a crime is suspected, law enforcement is in charge of collection and control of the evidence.[43,44,55,107] Make sure that if child abuse is suspected that law enforcement has received a report and are aware you are at the scene.

- Obtain appropriate search warrants – always consider best practice over consent to search.
- Observe as much of the details as possible.
- Use all senses: What do you see, hear, smell, feel, and question?
- Use intuition: What is missing; what seems odd, unexpected or too convenient?
- Utilize established protocols for evidence collecting, logging and chain of custody.
- Conduct thorough interviews of the informants, reporters, witnesses, suspects.
- Document and log all as soon as possible.

Document Details of Child:

- Photograph or videotape as much of the scene and evidence as possible.
- Describe the condition of the child:
  - Observable marks, bruises, injuries
  - Degree of alertness
  - Signs of distress
  - Physical state: skin temperature, color, lividity, etc
  - Position

Document Details of Family and Collateral Witnesses:

- Demeanor
- Appearance
- Actions
- Signs of intoxication or drug/alcohol use
- Any cultural, religious, ethic, social, medical, developmental requests or impairments
- Contact information, numbers, addresses at home and place of work.

Document Details of the Home Environment Inside and Outside:

- Home Environment:
  - Floor plan including patio, balcony, yards
  - Furniture lay out
  - Order or disorder of belongings, clothing, toys, etc.

- Cleanliness or level of health and safety risk
- Food and water—adequate amounts, storage, freshness
- Presence of medications or other substances (drugs, alcohol, etc)
- Working order and condition of appliances
- Communications—cell phones, landlines, answering machines, computers
- Odors, toxins, discoloration, fluids
- Noise levels and their source
- Sleeping areas – number of beds, types, condition, location, bedding, etc.
- Children's play area – playpens, jumpers, walkers, toys etc.
- Ventilation – doors, windows, screens
- Access—internal and external doors and windows open, closed, locked
- Temperature—water, interior house
- Pets—condition, care, safety
- Presence of weapons
- Items in garbage (in home and outside)

Features of the Surrounding Area:

- Apartment complex
- Neighborhood
- Community

Take Special Notice:

- Any objects that could possibly be involved in the mechanism of injury
- Anything that seems missing or out of place

Consultation and Follow Up:

- Maintain on-going analysis of evidence and consultation with other collaborating professionals to provide direction for next steps
- Formal analysis should be checked with prosecutor if evidence of crime

8. MAXIMIZE INFORMATION SHARING: Key to Effective Investigation

Legal Guidelines:

On-going Dilemma: If you share information you can be held for liability. If you fail to share information you can be held for liability. [31,32,108,112]

Know the Basic Laws:

- Sharing of information on child abuse cases is regulated by state and federal law.
- Understand where communication of suspected child abuse and neglect is required, permissible, or not allowed.

Special Appendix Guide to State Laws

- A "Guide to Reporting and Sharing Information about Abused Children" can be found in an appendix to this document. It is a guideline only and not intended for legal advice on any particular case or circumstance. It covers the following topics:
  - California Statutes Requiring or Limiting Communication on Child Abuse and Neglect Cases [74,75,76,77]
    - Mandated Reporters
      - Report of Suspected Child Abuse and Neglect
      - Confidentiality of Mandated Reporter Name
    - Medical and Healthcare Practitioners
      - Report of Suspected Child Abuse and Neglect
      - Report of Gunshot Wounds or Injuries from Assaultive / Abusive Conduct
      - Release of Records to Coordinate Healthcare of Dependent Children
    - Child Welfare (CPS) Social Workers
      - Report of Suspected Child Abuse and Neglect
      - Receipt of Mandated and Non-mandated Reports of Suspected Child Abuse
      - Cross-report of Suspected Child Abuse and Neglect to Law Enforcement
      - Report to California Child Abuse Central Index (CACI)
      - Confidentiality of Juvenile Cases
      - Release of Medical Records to Coordinate Healthcare of Dependent Children

- Law Enforcement
  - Report of Suspected Child Abuse and Neglect
  - Receipt of Mandated and Non-mandated Reports of Suspected Child Abuse
  - Cross-report of Suspected Child Abuse and Neglect to CPS
  - Report to California Child Abuse Central Index (CACI)
  - Ability to Keep Names of Minor Victims of a Crime Confidential
  - Interview Suspected Victims of Child abuse at School
  - Release of Criminal History to CPS when Investigating Child Abuse
  - Report to State Dept of Health Services Self-Inflicted Gunshot Wounds
- Prosecution
  - Receipt of Mandated and Non-mandated Reports of Suspected Child Abuse
  - Ability to Keep Names of Minor Victims of a Crime Confidential
- Multi-disciplinary Teams Definitions and Confidentiality Requirements [22]
  - Child Abuse
  - Domestic Violence Death Review
  - Child Death Review

- State Databases: Retrieving and Reporting Information
  - Child Abuse Central Index (CACI)
  - Child Welfare Services Case Management System (CWS/CMS)
  - California Law Enforcement Telecommunications System (CLETS)
- Federal Health Insurance Portability and Accountability Act (HIPAA) [14,31,32,53,67,71]
  - In Child Abuse Investigations
  - In Court Processes

Strengthening Professional Networks:

Special Circumstances to Consider:

- Investigations of Serious Crimes:

  The criminal investigation of serious crimes (e.g., homicide, multiple victim sexual assault) often requires the investigating officer to take a much stricter confidential approach in information sharing in order to control for leaks that could taint the investigation. However, this is not meant to give law enforcement permission not to collaborate in multi-agency investigations.

- Initial Reports of Suspicious Medical Conditions:

  Intake workers at Child Protection Hotlines need to remember that when physicians, nurses or hospital social workers call in to report a suspicious injury or medical condition of a child that they should not be expected to make a definitive diagnosis of abuse or non-abuse. The initial call requires a *suspicion of abuse only*. The report should be taken so that a police and CPS investigation can begin. Often times, various specialized tests, procedures and consultations are needed before a final diagnosis is made.

- Feedback to Expert Witnesses:

  Prosecutors should provide feedback on the outcome of the cases to the expert witnesses who testified or provided an evaluation so that they can improve their style or approach to testifying and learn more about the legal or public understanding of child abuse and neglect.

- Feedback to Mandated Reporters:

  Law Enforcement, CPS social workers are required by law to give feedback on the outcome of the investigations to mandated reporters. Although not all case information can be shared, giving feedback helps connect the reporter to the process and may increase their overall understanding of child abuse and neglect and the response system.

Building Professional Trust

- Build professional relationships to facilitate information sharing.
- Show professional courtesy and respect to promote collaboration.
- Respond timely to requests for information by other professionals.
- Maintain the appropriate confidentiality of information shared with you.
- Provide clear explanations when you cannot provide information.

Develop and maintain local databases;

- Local or Regional Databases:
  - Los Angeles County has the Family & Child Index (FCI) database. Specific county agencies contribute information about children and families that have come to their attention. Participants include CPS, DA, Sheriff, Public Social Services, Education, and Probation. Authorized personnel working to prevent identify or treat child abuse can query the database. If the search results in a hit, the names of the agencies and a contact number are obtained so that a teleconference can be arrange with two other county professionals—constituting a Multi-disciplinary Team—can discuss case specific information pursuant to Welfare & Institutions Code 830.
- ListServs.

  Many professional organizations and interest groups design ListServ distribution lists that allow interested people to send and receive electronic information and requests for information or consultation quickly
- Directories.

  Up-to-date electronic or hard copy files of local experts or professional contacts greatly ease communication. Contact information should include addresses, telephone numbers, email addresses, and fax numbers.
- Know how to access the databases, ListServs and directories
- Consult state and local legal experts when in doubt

9. SUPPORT VICTIMS AND THE FAMILY: Initial Assistance and Services

Basic Strategies

Taking a Supportive Approach

- A child death or severe injury is traumatic for the family and professionals.
- All professionals are responsible for the safety and well-being of the victim and family.
- Timely and comprehensive support services are the first steps in preventing future injuries or abuse.
- Investigating agents need to be objective but sensitive to the family and even to suspects until the process is complete.
- An overly zealous or aggressive investigation of child injuries may increase reluctance to cooperate on the part of the victim, family, suspect or witnesses.
- Understand the culture and languages of the families in your community. Know the fundamental cultural practices of each group and how to access appropriate interpreters and support services. [100,101,102]

Knowing What Information to Provide

- Parents have a right to know what happened and their child's medical status.
- Give a general explanation of the process underway:
  - Inform the family about the next steps
  - Provide them with recommended or needed service or referrals
  - Do not tip the family off to key investigative elements that could help them develop an alibi
- Consider when, where and in front of whom the questioning occurs. Find areas that afford privacy when doing interviews or collecting information in public areas.

Working with Auxiliary Service Providers

- Have auxiliary support professionals working with a family to assist other responders.
- Consider using grief and trauma counselors, school personnel, child life specialists, regional center or disability specialist, family preservation providers, domestic violence counselors, public social service workers, or legal aid representatives.
- Have a protocol to obtain interpreters for the many languages, including American Sign Language. Consider contacts for professionals with expertise working with people with communication disabilities (e.g., severe autism, hearing impairment).
- Maintain a resource list of contacts for families from underserved communities (e.g., homeless or undocumented) or those with special needs (e.g., medical, mental health, mobility or other disability).

10. STAY CONNECTED: Building Relationships for Future Cases

The team work continues after the first response. [8,24,27,30,48]

- Return calls and requests for information.
- Assist other professionals to navigate your agency if you are not directly involved in a case.
- Give feedback on case outcomes to professionals involved in the case
    - Share lessons learned
    - Improve skills and increase awareness
    - Reinforce a multidisciplinary network.
- Maintain a contact list for collaboration and consultation. Share the list with colleagues at your own agency, especially with the management.
- Have business cards available to share at all times.
- Have a system to review or mediate any inter-agency battles or problems
- Arrange opportunities for training and cross-training. Offer to do training for another agency.
- Encourage the development of a local multi-agency review team.
- Do site or ride-along visits at other agencies to see how they work and what the demands are.

Appendices and References

4 Appendices and References

CalEMA – The Guidelines – Bibliography Sheet

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Assessment of Child Abuse & Neglect in Medical Settings
Best Practices

Every medical facility that treats children should have as core practices: (1) a well-established and maintained in-house child abuse protocol; (2) commitment to inter-professional and inter-agency team approach in the review of all injuries to children; (3) links to local medical consultants and child abuse experts; and (4) frequent staff training.

Possible Models for Review & Management of Child

Best Practices Assessment Strategies / Level of Pediatric Services	*Outpatient Facilities, General ERs, or Rehab Facilities* (minimum)	*Pediatric Units, PICUs, Pediatric ER Special Trauma* (medium)	*Pediatric Trauma Centers* (maximum)
Well-Defined In-House Child Abuse Protocol & Reporting	✓	✓	✓
Periodic Training on Suspected Child Abuse (e.g., Severity of Injury & Environmental Risks)	✓	✓	✓
Daily Screening of Admissions and Suspicious Cases by MD, RN, Hospital Social Worker	✓	✓	✓
Case Log of Suspicious Cases	✓	✓	✓
Referral or Transfer Mechanism to Child Abuse Experts & Consultants	✓	✓	✓
Established Liaisons with Local Police & DCFS	✓	✓	✓
Identified SCAN Team Members Available as Needed	✓ *	✓	✓
Established Links to Consultants & Forensic Exam Experts		✓	✓
Formal Multi-agency SCAN Team with Police, DCFS, & Mental Health Members		✓ *	✓
Child Abuse Experts on Staff			✓
Participate in Multi-disciplinary Child Abuse Programs (e.g., Fatal or Non-Fatal Reviews)			✓
Provide Training & Consultation			✓
Annual Reports to Hospital & Community			✓

* Recommended

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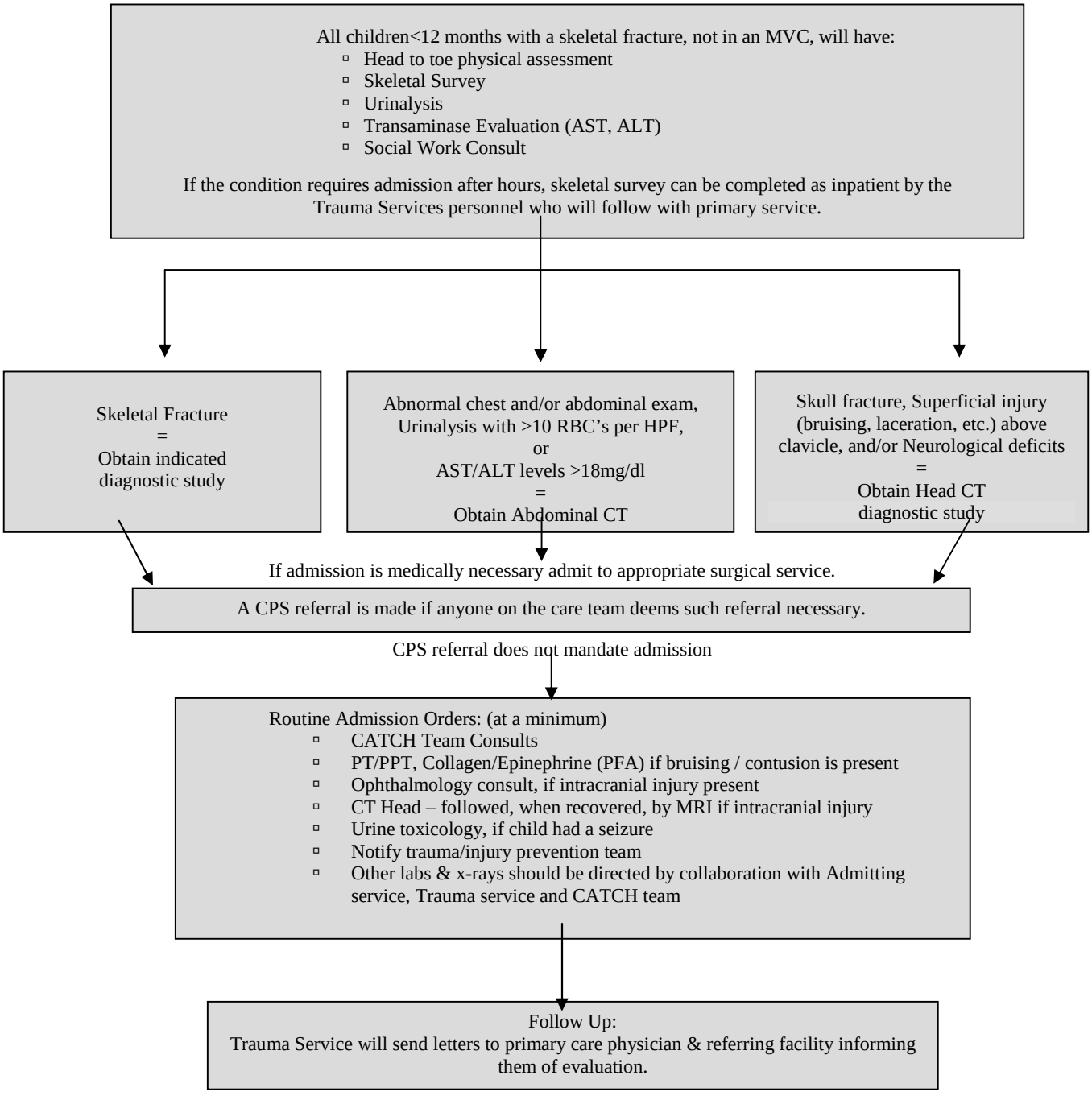
From ICAN Associates OES Grant Project:
Multi-Agency Identification & Investigation & Fatal Child Injury:
Guidelines for Networking, Communication & Collaboration

Traumatic Injury <12 Months Pathway

(Non-Motor Vehicle Collision – MVC)



Example from Robert Todd Maxson, M.D.
DCMC Trauma Services
Austin, TX
2008

SAMPLE: Possible Hospital Spreadsheet						
A	B	C	D	E	F	G
# Cause category	CAUSE	Other factors	Assault E code	Abuse, Neglect report	Report matches assault E code	Further action
1 Assault Abuse neglect	ASSAULT CHILD ABUSE	Injuries reflect abuse	E967.0	yes	yes	none
2 Assault other (1 reported, cleared)	ASSAULT	Injuries poorly explained	E968.0	yes	yes	1 New report by hospital
2 Late effects (1 cleared)	Organic brain syndrome	Old TBI	unk	no	NA	1 clarify original report
2 Bicycle, transport	unintended	All cleared	no	no	na	none
6 Unintended burn scald 5 cleared	Hot water	1 reported	yes	yes	yes	none
2 Unintended submersion	1 bathtub	1 neglect	unk	neglect	unk	1 New report by hospital
23 fall	1 reported	Injuries reflect abuse	E967.0	abuse	yes	none
5 MVT	0 reported	Safety issues	na	na	Na	none
3 environment	Heat exhaust	Left in car	unk	Unk	unk	1 find code for neglect in car
9 other	1 possible abuse	History unclear	unk	no	no	1 team review for possible report
7 Poison	1 unk	1 possible munchausen	Unk	Unk	Na	Team review possible munchausen
2 Struck by against	Abuse	Reported	E 967.0	abuse	2 match	none
3 suffocation	2 cleared, unintent	1 reported	E 967.0	Abuse	Match	none
SUMMARY OF STEP THREE AND FOUR						
	Two cases referred to team review for follow up or consultation					
	Two new reports by the hospital					
	Two possible new reports by the team					
	70 cases screened to 18 for expert review – step two					
	18 cases screened to 6 for team					
	6 for team resulted in two new reports, old case clarified and search for codes					

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2008

The following includes a small portion of ICD9CM codes.
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(See the HRSA web at **http://hrsa.gov/injuryreport/default.htm)**

INDEX TO EXTERNAL CAUSES OF INJURY (E CODE)

This section contains the index to the codes which classify environmental events, circumstances, and other conditions as the cause of injury and other adverse effects. Where a code from the section Supplementary Classification of External Causes of Injury and Poisoning (E800-E998) is applicable, it is intended that the E code shall be used in addition to a code from the main body of the classification. The injury cause is listed below by alphabetical category. Codes may note the injury, the cause, location, body parts involved, specific toxins, intent and if intentional the category of perpetrator. We will need experts to help us with this maze of information. The listing below is only meant to provide an impression of the extent of this maze of information.

Primarily codes for assault and unknown intent to match with child abuse reports.

ALPHABETIC INDEX TO EXTERNAL CAUSES OF INJURY

Abandonment
- causing exposure to weather conditions see Exposure
- child, with intent to injure or kill E968.4
- helpless person, infant, newborn E904.0
  - **with intent to injure or kill E968.4**

Abuse, (alleged) (suspected)
- **adult by**
  - **child E967.4**
  - **ex-partner E967.3**
  - **ex-spouse E967.3**
  - **partner E967.3**
  - **spouse E967.3**
- **child by**
  - **boyfriend of parent or guardian E967.0**
  - **child E967.4**
  - **father E967.0**
  - **female partner of parent or guardian E967.2**
  - **girlfriend of parent or guardian E967.2**
  - **grandchild E967.7**
  - **grandparent E967.6**
  - **male partner of parent or guardian E967.0**
  - **mother E967.2**
  - **non-related caregiver E967.8**
  - **other relative E967.7**
  - **other specified person(s) E967.1**
  - **sibling E967.5**
  - **stepfather E967.0**
  - **stepmother E967.2**
  - **unspecified person E967.9**

Accident (to) E928.9
- caused by, due to
  - cold (excessive) (see also Cold, exposure to) E901.9
  - corrosive liquid, substance NEC E924.1

cutting or piercing instrument (see also Cut) E920.9
environmental factors NEC E928.9
explosive material (see also Explosion) E923.9
heat (excessive) (see also Heat) E900.9
hot
liquid E924.0
caustic or corrosive E924.1
object (not producing fire or flames) E924.8
substance E924.9
caustic or corrosive E924.1
human bite E928.3
medical, surgical procedure
as, or due to misadventure - see Misadventure
late effect of - see Late effect
motor vehicle (on public highway) (traffic) E819
nontraffic, not on public highway - see categories E820-E825
not involving collision - see categories E816-E819
occurring (at) (in)
apartment E849.0
garage (place of work) E849.3
private (home) E849.0
highway E849.5
home (private) (residential) E849.0
institutional E849.7
hospital E849.7
house (private) (residential) E849.0
institution, residential E849.7
motel E849.6
orphanage E849.7
park (public) E849.4
mobile home E849.8
trailer E849.8
parking lot or place E849.8
playground (park) (school) E849.4
school (building) (private) (public) (state) E849.6
reform E849.7
swimming pool (public) E849.4
pedal cycle E826
roller skate E885.1
scooter (nonmotorized) E885.0
skateboard E885.2
Acid throwing E961
Anaphylactic shock, anaphylaxis (see also Table of Drugs and Chemicals) E947.9
due to bite or sting (venomous) - see Bite, venomous
Asphyxia, asphyxiation
mechanical means (see also Suffocation) E913.9
Aspiration
vomitus (with asphyxia, obstruction respiratory passage, suffocation) (see also Foreign body, aspiration, food) E911

Assault (homicidal) (by) (in) E968.9

Battered
baby or child (syndrome) - see Abuse, child; category E967

person other than baby or child - see Assault
Bean in nose E912
Bed set on fire NEC E898.0
Broken glass
fall on E888.0
injury by E920.8
Burning, burns (accidental) (by) (from) (on) E899
acid (any kind) E924.1
swallowed - see Table of Drugs and Chemicals
bedclothes (see also Fire, specified NEC) E898.0
candle (see also Fire, specified NEC) E898.1
caustic liquid, substance E924.1
swallowed - see Table of Drugs and Chemicals
chemical E924.1
from swallowing caustic, corrosive substance - see Table of Drugs and Chemicals
corrosive liquid, substance E924.1
swallowed - see Table of Drugs and Chemicals
electric current (see also Electric shock) E925.9
fire, flames (see also Fire) E899
homicide (attempt) (see also Assault, burning) E968.0
hot liquid E924.0
caustic or corrosive E924.1
tap water E924.2
inflicted by other person
stated as
homicidal, intentional (see also Assault, burning) E968.0
undetermined whether accidental or intentional (see also Burn, stated as undetermined whether accidental or intentional) E988.1
internal, from swallowed caustic, corrosive liquid, substance - matches (see also Fire, specified NEC) E898.1
medicament, externally applied E873.5
object (hot) E924.8
producing fire or flames - see Fire
oven (electric) (gas) E924.8
substance (hot) E924.9
boiling or molten E924.0
caustic, corrosive (external) E924.1
swallowed - see Table of Drugs and Chemicals
therapeutic misadventure

Cat
bite E906.3
scratch E906.8
Choking (on) (any object except food or vomitus) E912
Cold, exposure to (accidental) (excessive) (extreme) (place) E901.9
Collision (accidental) motor vehicle (on public highway) (traffic accident) E812
not on public highway, nontraffic accident E822
Conflagration
building or structure, except private dwelling (barn) (church) (convalescent or residential home) (factory) (farm outbuilding) (hospital) (hotel) or (institution (educational) causing explosion E891.0
private dwelling (apartment) (boarding house) (camping place) (caravan) (farmhouse) (home (private)) (house) (lodging house) (private garage) (rooming house) (tenement) E890.9
with or causing (injury due to) accident or injury NEC E890.9
burns, burning E890.3

carbon monoxide E890.2
smoke E890.2

Constriction, external
caused by
hair E928.4
other object E928.5
Cut, cutting (any part of body) (accidental) E920.9
homicide (attempt) E966
inflicted by other person
stated as
intentional, homicidal E966
undetermined whether accidental or intentional E986
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ICAN ASSOCIATES
FOR THE PREVENTION OF CHILD ABUSE
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Sample Collaborative Partnership Agreement (MOU)

Between _____ and Los Angeles County Inter-Agency Council on Child Abuse and Neglect Associates (ICAN-A)

This document serves as a collaborative partnership that ICAN-A and _____ intend to work together toward the mutual goal of improving the identification and investigation of severe and fatal child injuries. Both agencies believe that implementation of the *Multi-agency Identification and Investigation of Severe and Fatal Child Injury: Guidelines for Networking, Communication and Collaboration (The Guidelines*), as described herein, will further this goal. To this end, each agency agrees to participate in the program by coordinating/providing the following activities:

ICAN-A will coordinate the following activities with _____ through:

- ICAN-A staff being readily available to _____through providing assistance and consultation with *The Guidelines*
- Regularly scheduled meetings monthly with _____to discuss strategies, timetables, implementation of mandated services.
- Specifically:

To field test the *Model for Hospital-Based Child Severe Injury Review* section of *The Guidelines.*

Specific activities that will be undertaken between the two agencies and other specifics of the agreement:

Roles and Responsibilities of _____

- Field test the *Model for Hospital-Based Child Severe Injury Review* section of *The Guidelines* either throughout the entire agency, or designated section(s) or department(s)
  of the agency
- Inform ICAN-A of the outcomes, including general feedback, on the field test of the *Model for Hospital-Based Child Severe Injury Review* section of *The Guidelines*
- Notify ICAN-A of any delay, modification or termination of the field test for the *Model for Hospital-Based Child Severe Injury Review* section of *The Guidelines*

Roles and Responsibilities of ICAN-A

- Provide on-site training at the request of _____ on *The Guidelines* to its staff and to incur the costs of materials required for training;
- Arrange regularly scheduled contacts between ICAN staff and the _____ staff assigned to the program to collect feedback on the field test of the *Model for Hospital-Based Child Severe Injury Review* section of *The Guidelines*;
- Keep records of the progress and any problems in the implementation of *The Guidelines*;

Source Documentation:

- Maintain a hard copy of the *Multi-agency Identification and Investigation of Severe and Fatal Child Injury: Guidelines for Networking, Communication and Collaboration (The Guidelines*), including the *Model for Hospital-Based Child Severe Injury Review* section of *The Guidelines*
- Maintain a hard copy of the outcomes of all Data & Findings

We the undersigned, as collaboratives from _____and ICAN Associates, do hereby approve this document.

_____	_____
Deanne Tilton Project Director ICAN Associates	(Agency Representative) (Participating Agency)
_____	_____
Date	Date

Multi-Agency Identification and Investigation of Severe and Fatal Child Injury:
Guidelines for Networking, Communication and Collaboration

Special Appendix: A Guide to Reporting and Sharing Information about Abused Children

December 2008

<u>This guide is not intended to provide legal advice applicable to a particular case.</u>

It is intended to generally inform health care providers, social workers, law enforcement, prosecutors and mandated reporters about the ability to share information in the context of recognizing and responding appropriately to child abuse. Any questions about a specific case should be directed to legal counsel who represents the agency who is responding to child abuse.

The purpose of this guide is to assist health care providers, social workers, law enforcement, prosecutors, and mandated reporters in understanding what information they can share and obtain about an abused child.

What and when information can be shared depends upon the nature of the information, the status of the possessor, and who is the recipient of the information. Often there are threshold levels of suspicion that must exist before information can be disclosed. When there is multi-agency collaboration, there are specific rules related to information sharing that are statutorily created.

The federal Health Insurance Portability and Accountability Act regulates disclosure of medical information, but generally does not apply in the area of disclosing medical information related to child abuse because the federal government left the states to regulate themselves in the area of child abuse.

Finally, there are three government data bases that are used in the investigation and response to child abuse. The Child Abuse Central Index is a statewide index that receives substantiated reports of child abuse and maintains the information that is subsequently available to individuals and entities that investigate child abuse.

The Child Welfare Services/Case Management System is a statewide system that contains information available only to child welfare workers.

The California Law Enforcement Telecommunications Systems is a statewide system that records arrests and convictions and information from this system is available to law enforcement, prosecutors, and under limited circumstances to child welfare workers who are investigating or placing abused children.

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WHO ARE YOU?	RULES OF DISCLOSURE
Medical/Health Care Practitioner – Penal Code section 11160 .	• **Medical/health care providers are mandated to report abuse under two statutory schemes in the Penal Code.** Mandated reporting of child abuse by medical/health care practitioners and a broader group of reporters pursuant to the Child Abuse and Neglect Reporting Act, beginning at Penal Code section 11164, is described in the portion of this guide under Mandated Reporters. • **Penal Code section 11160 is a general reporting statute.** The statute requires an immediate report to local law enforcement when medical services are provided to any person who is suffering from an *injury* inflicted by a gunshot or to any person who is suffering from any wound or other physical injury resulting from "abusive or assaultive" conduct. • **Who must report?** A health practitioner employed in a health facility, clinic, physician's office, local or state public health department or a clinic or other type of health facility operated by a local or state public health department • **What must be reported?** "Abusive or assaultive" conduct must be reported and is defined in Penal Code section 11160(d) as involving the following offenses: (1) Murder; (2) Manslaughter; (3) Mayhem, (4) Aggravated mayhem, (5) Torture, (6) Assault with intent to commit mayhem, rape, sodomy, or oral copulation, (7) Administering controlled substances or anesthetic to aid in commission of a felony, (8) Battery (9) Sexual battery, (10) Incest, (11) Throwing any vitriol, corrosive acid, or caustic chemical with intent to injure or disfigure, (12) Assault with a stun gun or taser, (13) Assault with a deadly weapon, firearm, assault weapon, or machinegun, or by means likely to produce great bodily injury, (14) Rape, (15) Spousal rape, (16) Procuring any female to have sex with another man, (17) *Child abuse or endangerment*, (18) Abuse of spouse or cohabitant, (19) Forcible Sodomy, (20) Lewd and lascivious acts with a child, (21) Forcible Oral copulation, (22) Sexual penetration, (23) Elder abuse, (24) An attempt to commit any crime specified above. • **Timing of the report.** A telephonic report must be made immediately or as soon as practically possible. This telephonic report must be followed by written report prepared on an OES form. This form must be sent to law enforcement within two working days of receiving the information regarding the injured person. Penal Code sect. 11160(b)(1-3) • **Contents of the Report.** The report shall include, but shall not be limited to, the following: (1) the name of the injured person, if known; (2) the injured person's whereabouts;(3) the character and extent of the person's injuries; and, (4) the identity of any person the injured person alleges inflicted the wound, other injury, or assaultive or abusive conduct upon the injured person. Penal Code section 11160(b)(4).

	• **Standard for Making a Report.** Any health practitioner employed in a health facility, clinic, physician's office, local or state public health department, or a clinic or other type of facility operated by a local or state public health department who, in his or her professional capacity or within the scope of his or her employment, provides medical services for a physical condition to a patient whom he or she knows or reasonably suspects is a person who has been injured as a result of assaultive conduct, shall immediately make a report to local law enforcement. Penal Code 11160(a) • **What is reasonable suspicion?** "Reasonably suspects" means that it is objectively reasonable for a person to entertain a suspicion, based upon facts that could cause a reasonable person in a like position, drawing, when appropriate, on his or her training and experience, to suspect the injury arose from assaultive conduct. Penal Code section 11166(a)(1) • **Who must this information be reported to?** The local law enforcement agency. Penal Code section 11160(b)(2). • **Immunity from liability.** A health practitioner who makes a report in accordance with this article shall not incur civil or criminal liability as a result of any report required or authorized by this article. Penal Code section 11161.9. • **Failure to report is a misdemeanor.** A failure to report is a misdemeanor, punishable by imprisonment in a county jail not exceeding six months, or by a fine not exceeding one thousand dollars ($1,000), or by both that fine and imprisonment. Penal Code section 11162. • **When two people working together are required to make a report.** When two or more persons who are required to report and they agree as a team that one of team members will report, a single report may be filed on behalf of the team by person designated to report. Any team member who has knowledge that the designated reporter failed to report is liable to make a report. Penal Code section 11160(e) • **Reporting duties are individual.** Penal Code section 11160(f). • **No supervisor or administrator shall impede or inhibit reporting.** Penal Code section 11160(g) • **Confidentiality of mandated reports.** Mandated reports shall be kept confidential by the health facility, clinic, or physician's office that submitted the report, and by local law enforcement agencies, and shall only be disclosed by local law enforcement agencies to those involved in the investigation of the report or the enforcement of a criminal law implicated by a report. In no case shall the person suspected or accused of inflicting the

	wound, other injury, or assaultive or abusive conduct upon the injured person or his or her attorney be allowed access to the injured person's whereabouts. Reports of suspected child abuse and information contained therein may be disclosed only to persons or agencies with which investigations of child abuse are coordinated. Penal Code section 11163.2 (b-c). • **A provider of health care may disclose any medical information to a county social worker, a probation officer, or any other person who is legally authorized to have custody or care of a minor for the purpose of coordinating health care services and medical treatment provided to the minor.** This information shall not be further disclosed by the recipient unless the disclosure is for the purpose of coordinating health care services and medical treatment of the minor and the disclosure is authorized by law. Civil Code section 56.103 (a-d) Note that this disclosure is discretionary on the part of the health care provider in a situation where the medical information in not related to abuse investigation but is disclosed for the purpose of continuity of health care. • **A provider of health care may disclose mental health information to a probation officer, a county social worker or any person who is legally authorized to have custody or care of a minor for the purpose of coordinating the minors health care services and medical treatment, mental health services, or services for developmental disabilities.** This information shall not be further disclosed by the recipient unless the disclosure is for the purpose of coordinating health care services and medical treatment of the minor and the disclosure is authorized by law. Welfare and Institutions Code section 5328.04 Note that this disclosure is discretionary on the part of the health care provider in a situation where the medical information in not related to abuse investigation but is disclosed for the purpose of continuity of health care. (Effective 1-1-09) This law extends the ability of health care providers to discretionarily provide not only medical information as provided for in Civil Code section 56.103 (as referenced in the above preceding section), but also mental health information, related to children in custody and is disclosed for the purpose of continuity of care.

Child Welfare Department Caseworkers and Probation Officers	• **Welfare Department Caseworkers and Probation Officers are mandated reporters.** Penal Code section lll65.7(a)(18) • **Child Support/Welfare Agencies also receive mandated and non-mandated reports of abuse.** Reports of suspected child abuse or neglect shall be made by mandated reporters to any police department or sheriff's department, not including a school district police or security department, county probation department, if designated by the county to receive mandated reports, or the county welfare department. Any of those agencies shall accept a report of suspected child abuse or neglect whether offered by a mandated reporter or another person, or referred by another agency. Penal Code section 11165.9. The receiving of a report triggers a duty to cross report. • **The duty to cross report.** A county probation or welfare department shall immediately, or as soon as practicably possible, report by telephone, fax, or electronic transmission to the law enforcement agency having jurisdiction over the case, to the agency given the responsibility for investigation of cases under Section 300 of the Welfare and Institutions Code, and to the district attorney's office every known or suspected instance of child abuse or neglect. A county probation or welfare department also shall send, fax, or electronically transmit a written report thereof within 36 hours of receiving the information concerning the incident to any agency to which it makes a telephone report under this subdivision. Penal Code section 11166(j). • **The duty to report to the Child Abuse Central Index.** Child welfare workers and probation departments must send a written report to the Child Abuse Central Index. Penal Code section 11169(a) See the Child Abuse Central Index section in this guide. • **The duty to keep information about juveniles confidential.** Records of child involved in the dependency or delinquency system are confidential. They may be disclosed following a petition, subsequent judicial review, and then a court order under Welfare and Institutions Code section 827. • **Medical information that is provided to a social worker or a probation officer for the purpose of coordinating health may be further disclosed by the social worker or probation officer for the purpose of health care coordination.** Note that disclosure of non-abuse related medical information is discretionary on the part of a health care provider. Civil Code section 56.103(a)

Law Enforcement	• **Peace Officers are mandated reporters.** Penal Code section 11165.7(a)(19). • **Peace officers also receive mandated and non-mandated reports of abuse.** Reports of suspected child abuse or neglect shall be made by mandated reporters to

Reports of suspected child abuse or neglect shall be made by mandated reporters, to any police department or sheriff's department, not including a school district police or security department, county probation department, if designated by the county to receive mandated reports, or the county welfare department. Any of those agencies shall accept a report of suspected child abuse or neglect whether offered by a mandated reporter or another person, or referred by another agency. Penal Code section11165.9. The receiving of a report triggers a duty to cross report.

- **The duty to cross report.** A law enforcement agency shall immediately, or as soon as practicably possible, report by telephone, fax, or electronic transmission to the agency given responsibility for investigation of cases under Section 300 of the Welfare and Institutions Code and to the district attorney's office every known or suspected instance of child abuse or neglect reported to it and also shall send, fax, or electronically transmit a written report thereof within 36 hours of receiving the information concerning the incident to any agency to which it makes a telephone report under this subdivision. Penal Code section 11166(k).

- **The duty to report to the Child Abuse Central Index.** Law enforcement must send a written report to the Child Abuse Central Index. Penal Code section 11169(a) See the Child Abuse Central Index section in this guide.

- **The duty to keep information about minor victims confidential.** Penal Code section 293 requires that any employee of a law enforcement agency who personally receives a report from any person, alleging that the person making the report has been the victim of a sex offense, shall inform that person that his or her name will become a matter of public record unless he or she requests that it not become a matter of public record, pursuant to Section 6254 of the Government Code. The exceptions to this rule are that this information can be given to prosecutors, parole agents, and other public agencies that are authorized by law to have the information. Government Code sections 6254 (f) provides that the name of a victim of any crime defined by Section 220, 261, 261.5, 262, 264, 264.1, 265, 266, 266a, 266b, 266c, 266e, 266f, 266j, 267, 269, 273a, 273d, 273.5, 285, 286, 288, 288a, 288.2, 288.3, 288.3 ,288.5, 288.7, 289, 422.6, 422.7, 422.75, 646.9 or 647.6 of the Penal Code may be withheld at the victim's request, or at the request of the victim's parent or guardian if the victim is a minor. The listed code sections are crimes of sexual assault, child abuse, stalking and terrorist threats.

- **Law enforcement interviews of children at school.** Whenever a representative of a government agency investigating suspected child abuse or neglect or the State Department of Social Services deems it necessary, a suspected victim of child abuse or neglect may be interviewed during school hours, on school premises, concerning a report of suspected child abuse or neglect that occurred within the child's home or out-

	of-home care facility. The child shall be afforded the option of being interviewed in private or selecting any adult who is a member of the staff of the school, including any certificated or classified employee or volunteer aide, to be present at the interview. A representative of the agency investigating suspected child abuse or neglect or the State Department of Social Services shall inform the child of that right prior to the interview. Penal Code section 11174.3 (a). • **Can law enforcement provide child welfare workers with criminal history information when child abuse is being investigated?** Criminal justice personnel shall cooperate with requests for criminal history information from authorized child welfare workers and shall provide the information to the requesting entity in a timely manner. Welfare and Institutions Code section 16504.5(c). • **Duty to report self-inflicted gunshot wounds of minors to State Department of Health Services**. Each lead law enforcement agency investigating an incident shall report to the State Department of Health Services any information obtained that reasonably supports the conclusion that a child 18 years of age or younger suffered an unintentional or self-inflicted gunshot wound inflicted by a firearm that was sold or transferred in this state, or manufactured in this state.

Prosecutors and Courts	• **Prosecutors and courts are not mandated reporters.** • **Prosecutors and courts can keep the names of child abuse victims confidential.** Prosecutors can refuse to release the names of victims pursuant to Government Code sections 6254 (f) of any crime defined by Section 220, 261, 261.5, 262, 264, 264.1, 265, 266, 266a, 266b, 266c, 266e, 266f, 266j, 267, 269, 273a, 273d, 273.5, 285, 286, 288, 288a, 288.2, 288.3, 288.3 ,288.5, 288.7, 289, 422.6, 422.7, 422.75, 646.9 or 647.6 of the Penal Code upon request of a victim, or at the request of the victim's parent or guardian if the victim is a minor. The listed code sections crimes of sexual assault, child abuse, stalking and terrorist threats. The court, at the request of the alleged victim, may order the identity of the alleged victim in all records and during all proceedings to be either Jane Doe or John Doe, if the court finds that such an order is reasonably necessary to protect the privacy of the person and will not unduly prejudice the prosecution or the defense. Penal Code section 293.5(a) The crime against the victim must be one of the crimes listed above. The listed code sections are crimes of sexual assault, child abuse, stalking and terrorist threats. • **Prosecutors receive reports of child abuse.** Penal Code section 11166(j-k)

Mandated Reporter[1]	• **"The Child Abuse and Neglect Reporting Act, California Penal Code sections 11164 through 11174.3, contains an elaborate system for reporting and cross-reporting known and suspected cases of child abuse for the purpose of**

[1] (1) A teacher.
(2) An instructional aide.
(3) A teacher's aide or teacher's assistant employed by any public or private school...
(4) A classified employee of any public school.
(5) An administrative officer or supervisor of child welfare and attendance, or a certificated pupil personnel employee of any public or private school...
(6) An administrator of a public or private day camp.
(7) An administrator or employee of a public or private youth center, youth recreation program, or youth organization.
(8) An administrator or employee of a public or private organization whose duties require direct contact and supervision of children.
(9) Any employee of a county office of education or the California Department of Education, whose duties bring the employee into contact with children on a regular basis.
(10) A licensee, an administrator, or an employee of a licensed community care or child day care facility.
(11) A Head Start program teacher.
(12) A licensing worker or licensing evaluator employed by a licensing agency as defined in Section 11165.11.
(13) A public assistance worker.
(14) An employee of a child care institution, including, but not limited to, foster parents, group home personnel, and personnel of residential care facilities.
(15) A social worker, probation officer, or parole officer.
(16) An employee of a school district police or security department.
(17) Any person who is an administrator or presenter of, or a counselor in, a child abuse prevention program in any public or private school.
(18) A district attorney investigator, inspector, or local child support agency caseworker unless the investigator, inspector, or caseworker is working with an attorney appointed pursuant to Section 317 of the Welfare and Institutions Code to represent a minor.
(19) A peace officer, as defined in Chapter 4.5 (commencing with Section 830) of Title 3 of Part 2, who is not otherwise described in this section.
(20) A firefighter, except for volunteer firefighters.
(21) A physician, surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, optometrist, marriage, family and child counselor, clinical social worker, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.
(22) Any emergency medical technician I or II, paramedic, or other person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code.
(23) A psychological assistant registered pursuant to Section 2913 of the Business and Professions Code.
(24) A marriage, family, and child therapist trainee, as defined in subdivision (c) of Section 4980.03 of the Business and Professions Code.
(25) An unlicensed marriage, family, and child therapist intern registered under Section 4980.44 of the Business and Professions Code.
(26) A state or county public health employee who treats a minor for venereal disease or any other condition.
(27) A coroner.
(28) A medical examiner, or any other person who performs autopsies.
(29) A commercial film and photographic print processor, as specified in subdivision (e) of Section 11166. As used in this article, "commercial film and photographic print processor" means any person who develops exposed photographic film into negatives, slides, or prints, or who makes prints from negatives or slides, for compensation. The term includes any employee of such a person; it does not include a person who develops film or makes prints for a public agency.
(30) A child visitation monitor. As used in this article, "child visitation monitor" means any person who, for financial compensation, acts as monitor of a visit between a child and any other person when the monitoring of that visit has been ordered by a court of law.
(31) An animal control officer or humane society officer. For the purposes of this article, the following terms have the following meanings:
(A) "Animal control officer" means any person employed by a city, county, or city and county for the purpose of enforcing animal control laws or regulations.
(B) "Humane society officer" means any person appointed or employed by a public or private entity as a humane officer who is qualified pursuant to Section 14502 or 14503 of the Corporations Code.
(32) A clergy member, as specified in subdivision (d) of Section 11166. As used in this article, "clergy member" means a priest, minister, rabbi, religious practitioner, or similar functionary of a church, temple, or recognized denomination or organization.
(33) Any custodian of records of a clergy member, as specified in this section and subdivision (d) of Section 11166.
(34) Any employee of any police department, county sheriff's department, county probation department, or county welfare department.
(35) An employee or volunteer of a Court Appointed Special Advocate program, as defined in Rule 1424 of the California Rules of Court.
(36) A custodial officer as defined in Section 831.5.
(37) Any person providing services to a minor child under Section 12300 or 12300.1 of the Welfare and Institutions Code

protecting children from abuse. The whole system depends on professionals such as doctors, nurses, school personnel and peace officers who initially receive reports of child abuse to investigate and, where warranted, report those accounts to the appropriate agencies. If these professionals, including the police, simply ignore those reports, the Legislature's entire scheme of child abuse prevention is thwarted." *Alejo v. City of Alhambra* (l999) 75 Cal. App. 4th 1180.

- **Mandated reporters are required by law to report child abuse and neglect whether or not there is an actual and current presenting injury from the abuse.** Penal Code section 11166(a).
- **Who is a mandated reporter?** See footnote 1. for the complete list of mandated reporters listed in Penal Code section 11165.7.
- **A "child" means a person under the age of 18.** Penal Code section 11165.
- **Definition of child abuse and neglect.** The definition includes physical injury or death inflicted by other than accidental means upon a child by another person, sexual abuse as defined in Section 11165.1, neglect as defined in Section 11165.2, the willful harming or injuring of a child or the endangering of the person or health of a child, as defined in Section 11165.3, and unlawful corporal punishment or injury as defined in Section 11165.4. Penal Code section 11165.6.
- **Timing of the report**. The mandated reporter shall make an initial report to the agency immediately or as soon as is practicably possible by telephone and the mandated reporter shall prepare and send, fax, or electronically transmit a written follow up report thereof within 36 hours of receiving the information concerning the incident. Penal Code section 11166(a).
- **Contents of the report.** Reports of suspected child abuse or neglect pursuant to Section 11166 or Section 11166.05 shall include the name, business address, and telephone number of the mandated reporter; the capacity that makes the person a mandated reporter; and the information that gave rise to the reasonable suspicion of child abuse or neglect and the source or sources of that information. If a report is made, the following information, if known, shall also be included in the report: the child's name, the child's address, present location, and, if applicable, school, grade, and class; the names, addresses, and telephone numbers of the child's parents or guardians; and the name, address, telephone number, and other relevant personal information about the person or persons who might have abused or neglected the child. The mandated reporter shall make a report even if some of this information is not known or is uncertain to him or her. Penal Code 11167(a). The mandated reporter may include with the report any non-privileged documentary evidence the mandated reporter possesses relating to the incident. Penal Code section 11166(a).

- **Standard for making a report**. a mandated reporter shall make a report to an agency specified in Section 11165.9 whenever the mandated reporter, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child whom the mandated reporter knows or *reasonably suspects* has been the victim of child abuse or neglect. Penal Code section 11166 (a).
- **What is "reasonable suspicion"?** "Reasonable suspicion" means that it is objectively reasonable for a person to entertain a suspicion, based upon facts that could cause a reasonable person in a like position, drawing, when appropriate, on his or her training and experience, to suspect child abuse or neglect. For the purpose of this article, the pregnancy of a minor does not, in and of itself, constitute a basis for a reasonable suspicion of sexual abuse. Penal Code section 11166(a)(1).
- **Who this information must be reported to?** Reports of suspected child abuse or neglect shall be made by mandated reporters, to any police department or sheriff's department, not including a school district police or security department, county probation department, if designated by the county to receive mandated reports, or the county welfare department. Penal Code section 11165.9.
- **Immunity from liability.** No mandated reporter shall be civilly or criminally liable for any report required or authorized by this article, and this immunity shall apply even if the mandated reporter acquired the knowledge or reasonable suspicion of child abuse or neglect outside of his or her professional capacity or outside the scope of his or her employment. Any other person reporting a known or suspected instance of child abuse or neglect shall not incur civil or criminal liability as a result of any report authorized by this article unless it can be proven that a false report was made and the person knew that the report was false or was made with reckless disregard of the truth or falsity of the report, and any person who makes a report of child abuse or neglect known to be false or with reckless disregard of the truth or falsity of the report is liable for any damages caused. Penal Code section 11172(a).
- **A failure to report is a misdemeanor.** Any mandated reporter who fails to report an incident of known or reasonably suspected child abuse or neglect as required by this section is guilty of a misdemeanor punishable by up to six months confinement in a county jail or by a fine of one thousand dollars ($1,000) or by both that imprisonment and fine. Penal Code section 11166 (b).
- **Confidentiality of a mandated reporter.** The identity of all persons who report shall be confidential and disclosed only among agencies receiving or investigating mandated reports, to the prosecutor in a criminal prosecution or in an action initiated under Section 602 of the Welfare and Institutions Code arising from alleged child abuse, or to counsel appointed pursuant to subdivision (c) of Section 317 of the Welfare and Institutions

	Code, or to the county counsel or prosecutor in a proceeding under Part 4 (commencing with Section 7800) of Division 12 of the Family Code or Section 300 of the Welfare and Institutions Code, or to a licensing agency when abuse or neglect in out-of-home care is reasonably suspected, or when those persons waive confidentiality, or by court order .No agency or person listed in this subdivision shall disclose the identity of any person who reports under this article to that person's employer, except with the employee's consent or by court order. Penal Code section 11167. • **Does a prosecutor who receives the name of the mandated reporter have to disclose the name of the reporter when a crime is committed?** Yes, prosecutors must disclose the names and addresses of all persons they intend to call to trial and all written or recorded statements of witnesses they intend to call to trial. Penal Code section 1054.1 In addition, the case of *Brady v. Maryland (1963) 373U.S. 83* requires prosecutors to disclose all evidence and information that would exonerate a criminal defendant when that information is possessed by a member of the prosecutorial team. The concept of a prosecutorial team is a broad concept that includes police agencies. • **Confidentiality of the Report.** Reports of suspected child abuse or neglect and information contained therein may be disclosed only to the following: (1) Persons or agencies to whom disclosure of the identity of the reporting party is permitted under Section 11167. (2) Persons or agencies to which disclosure of information is permitted under subdivision (b) of Section 11170 or subdivision (a) of Section 1170.5. (3) Persons or agencies with which investigations of child abuse or neglect are coordinated. (4) Multidisciplinary personnel teams. (5) Persons or agencies responsible for the licensing of facilities which care for children. (6) The State Department of Social Services or any county licensing agency which has contracted with the state.(7) Hospital SCAN teams. As used in this paragraph, “hospital scan team” means a team of three or more persons established by a hospital, or two or more hospitals in the same county, consisting of health care professionals and representatives of law enforcement and child protective services, the members of which are engaged in the identification of child abuse/neglect. The disclosure authorized by this section includes disclosure among all hospital scan teams. (8) Coroners and medical examiners when conducting a post mortem examination of a child. (9) The Board of Parole Hearings. (11) Persons who have been identified by the DOJ as listed in the Child Abuse Central Index. (12) Out-of-state law enforcement agencies conducting an investigation of child abuse/neglect only when an agency makes the request for reports of suspected child abuse/neglect in writing and on official letterhead. (13) Out-of-state agencies responsible for approving prospective foster or adoptive parents or relative caregivers for placement of a child only when the agency makes the request for information in writing on official letterhead (14) each chairperson of a county child death review team. (15) Authorized persons within county health departments. Penal Code sect. 11167.5 (b).

	• **Liability for Disclosing a Child Abuse Report.** Any violation of confidentiality is a misdemeanor punishable by imprisonment in a county jail not to exceed six months, by a fine of five hundred dollars ($500), or by both that imprisonment and fine. Penal Code section 11167.5(a). • **When two people working together are required to make a report.** When two or more persons who are required to report and they agree as a team that one of team members will report, a single report may be filed on behalf of the team by person designated to report. Any team member who has knowledge that the designated reporter failed to report is liable to make a report. Penal Code section 11166(h). • **Reporting duties are individual.** Penal Code section 11166(h)(i)(1). • **Some special rules related to reporting child abuse and neglect:** 1. **A physician, dentist or surgeon can X-ray a child without parental consent if they suspect abuse.** Penal Code section 11171.2 2. **A police officer can ask a judge to approve X-rays of a child they suspect is abused.** Penal Code section 11171.5 3. **A mandated reporter may report emotional abuse, but is not required to report.** Penal Code section 11166.05 4. **Maternal substance abuse is not, by itself, a basis for reporting child abuse and neglect. However, it does trigger the duty to assess the risk to a child further. This report can only be made to the county welfare agency or a county probation department.** Penal Code section 11165.14. • **Abuse of a child at school requires that a report also be sent to a school board or the county office of education.** Penal Code section 11165.14
Multi-Disciplinary Team Member/Child Abuse	• **Who can be on the team?** "Multidisciplinary personnel" means any team of three or more persons who are trained in the prevention, identification, and treatment of child abuse and neglect cases and who are qualified to provide a broad range of services related to child abuse. The team may include but not be limited to: (1) Psychiatrists, psychologists, marriage and family therapists, or other trained counseling personnel. (2) Police officers or other law enforcement agents. (3) Medical personnel with sufficient training to provide health services. (4) Social workers with experience or training in child abuse prevention. (5) Any public or private school teacher, administrative officer, supervisor of child welfare and attendance, or certificated pupil personnel employee. Welfare and Institutions Code section 18951. • What information can be shared on a team? Members of a multidisciplinary personnel

	team engaged in the prevention, identification, and treatment of child abuse may disclose and exchange information and writings to and with one another relating to any incidents of child abuse that may also be a part of a juvenile court record or otherwise designated as confidential under state law. Welfare and Institutions Code section 830. • **"Child abuse" for the purposes of sharing information with a team**. Means a situation in which a child suffers from any one or more of the following: (1) serious physical injury inflicted upon the child by other than accidental means; (2) harm by reason of intentional neglect or malnutrition or sexual abuse; (3) going without necessary and basic physical care;(4) willful mental injury, negligent treatment, or maltreatment of a child under the age of 18 years by a person who is responsible for the child's welfare under circumstances that indicate that the child's health or welfare is harmed or threatened thereby, as determined in accordance with regulations prescribed by the Director of Social Services; and, (5) any condition that results in the violation of the rights or physical, mental, or moral welfare of a child or jeopardizes the child's present or future health, opportunity for normal development or capacity for independence. Welfare and Institutions Code section 18951 (e)(1-5). • Standard for Sharing Information. The team member reasonably believes it is generally relevant to the prevention, identification, or treatment of child abuse. Welfare and Institutions Code section 830. • **The duty to keep the information shared within the team confidential.** All discussions relative to the disclosure or exchange of any such information or writings during team meetings are confidential and, notwithstanding any other provision of law, testimony concerning any such discussion is not admissible in any criminal, civil, or juvenile court proceeding. Welfare and Institutions Code section 830 Please note that the discussions about the information are not admissible in any criminal, civil or juvenile court proceeding. The information itself, however, is not necessarily confidential and can be appropriately disclosed in court, to law enforcement or to other persons or agencies with which investigations of child abuse are coordinated. • **Disclosure of information in the context of a Multi-Disciplinary Child Abuse Team is not mandatory.** The statutory language authorizing sharing of information uses the permissive "may" and does not compel information to be shared.
Multi-Disciplinary Team/Domestic Violence Death Review Penal Code section 11163.3 – 11163.6	• **Who can be on the team?** County domestic violence death review teams shall be comprised of, but not limited to, the following: (1) Experts in the field of forensic pathology. (2) Medical personnel with expertise in domestic violence abuse. (3) Coroners and medical examiners. (4) Criminologists. (5) District attorneys and city attorneys. (6) Domestic violence shelter service staff and battered women's advocates. (7) Law enforcement personnel. (8) Representatives of local agencies that

	advocates. (7) Law enforcement personnel. (8) Representatives of local agencies that are involved with domestic violence abuse reporting. (9) County health department staff who deal with domestic violence victims' health issues. (10) Representatives of local child abuse agencies. (11) Local professional associations of persons described in (1) to (10), inclusive. Penal Code section 11163.3 (d). • **Each county can develop their own protocol.** Each county may establish an interagency domestic violence death review team to assist local agencies in identifying and reviewing domestic violence deaths, including homicides and suicides, and facilitating communication among the various agencies involved in domestic violence cases. Interagency domestic violence death review teams have been used successfully to ensure that incidents of domestic violence and abuse are recognized and that agency involvement is reviewed to develop recommendations for policies and protocols for community prevention and intervention initiatives to reduce and eradicate the incidence of domestic violence. Penal Code section 11163.3(a). • **Records of the Child Death Review Team are confidential.** An oral or written communication or a document shared within or produced by a domestic violence death review team related to a domestic violence death review is confidential and not subject to disclosure or discoverable by a third party. An oral or written communication or a document provided by a third party to a domestic violence death review team, or between a third party and a domestic violence death review team, is confidential and not subject to disclosure or discoverable by a third party. Notwithstanding the foregoing, recommendations of a domestic violence death review team upon the completion of a review may be disclosed at the discretion of a majority of the members of the domestic violence death review team. Each organization represented on a domestic violence death review team may share with other members of the team information in its possession concerning the victim who is the subject of the review or any person who was in contact with the victim and any other information deemed by the organization to be pertinent to the review. Any information shared by an organization with other members of a team is confidential. This provision shall permit the disclosure to members of the team of any information deemed confidential, privileged, or prohibited from disclosure by any other statute. Penal Code section 11163.3 (e-g). • **Information can be disclosed to a Domestic Violence Death Review Team by outside entities.** Written and oral information may be disclosed to a domestic violence death review team established pursuant to this section. The team may make a request in writing for the information sought and the person or entity disclosing may rely on the request in determining whether information may be disclosed to the team. Penal Code section 11163.3(g). • **What information can be disclosed to the Domestic Violence Death Review Team?**

	The following information can be shared: (1) medical information; (2) mental health information; (3) information from elder abuse reports and investigations, except the identity of persons who have made reports; (4) information from child abuse reports and investigations, except the identity of persons who have made reports, which shall not be disclosed; (5) state summary criminal history information, criminal offender record information, and local summary criminal history information; (6) information pertaining to reports by health practitioners of persons suffering from physical injuries inflicted by means of a firearm or of persons suffering physical injury where the injury is a result of assaultive or abusive conduct, and information relating to whether a physician referred the person to local domestic violence services; (7) information in any juvenile court proceeding; (8) information maintained by the Family Court, including information relating to the Family Conciliation Court Law; (9) information provided to probation officers in the course of the performance of their duties, including, but not limited to, the duty to prepare reports as well as the information on which these reports are based; and, (10) records of in-home supportive services. Penal Code section 11163(g). • **This information can be disclosed to the team without violating rules of privilege and confidentiality.** The disclosure of written and oral information authorized under this subdivision shall apply notwithstanding Sections 2263, 2918, 4982, and 6068 of the Business and Professions Code, or the lawyer-client privilege protected by Article 3 (commencing with Section 950) of Chapter 4 of Division 8 of the Evidence Code, the physician-patient privilege protected by Article 6 (commencing with Section 990) of Chapter 4 of Division 8 of the Evidence Code, the psychotherapist-patient privilege protected by Article 7 (commencing with Section 1010) of Chapter 4 of Division 8 of the Evidence Code, the sexual assault counselor-victim privilege protected by Article 8.5 (commencing with Section 1035) of Chapter 4 of Division 8 of the Evidence Code, and the domestic violence counselor-victim privilege protected by Article 8.7 (commencing with Section 1037) of Chapter 4 of Division 8 of the Evidence Code. • **Information sharing in the context of Domestic Violence Death Review Team is not mandatory.** No individual or agency that has information shall be required to disclose information. The intent is to allow the voluntary disclosure of information by the individual or agency that has the information. Penal Code section 11163.3(g)(1).

Multi-Disciplinary Team/Child Death Review Penal Code sections 11174.32 – 11174.35	• **Who can be on the team?** In developing an interagency child death review team and an autopsy protocol, each county, working in consultation with local members of the California State Coroner's Association and county child abuse prevention coordinating councils, may solicit suggestions and final comments from persons, including, but not limited to, the following: (1) Experts in the field of forensic pathology (2) Pediatricians with expertise in child abuse (3) Coroners and medical examiners.(4) Criminologists (5) District attorneys (6) Child protective services staff (7) Law enforcement

	personnel (8) Representatives of local agencies which are involved with child abuse or neglect reporting (9) County health department staff who deals with children's health issues (10) Local professional associations of persons described in (1) to (9), inclusive. Penal Code section 11174.32(c). • **Each county can develop their own protocol.** Each county may establish an interagency child death review team to assist local agencies in identifying and reviewing suspicious child deaths and facilitating communication among persons who perform autopsies and the various persons and agencies involved in child abuse or neglect cases. Interagency child death review teams have been used successfully to ensure that incidents of child abuse or neglect are recognized and other siblings and non-offending family members receive the appropriate services in cases where a child has expired. Penal Code section 1174.32 (b). • **Records of the Child Death Review Team are confidential.** Records exempt from disclosure to third parties pursuant to state or federal law shall remain exempt from disclosure when they are in the possession of a child death review team. Penal Code section 11174.32(d). When the team issues its yearly report, the last name of the deceased child shall be kept confidential unless the name has already been publicly disclosed. Penal Code section 1174.32(e). • **The Child Death Review Team must issue an annual report.** No less than once each year, each child death review team shall make available to the public findings, conclusions and recommendations of the team, including aggregate statistical data on the incidences and causes of child deaths. Penal Code section 1174.32(e). • **Disclosure of information in the context of a Child Death Review Team is not mandatory.** The statutory language authorizing sharing of information uses the permissive "may" and does not compel information to be shared.

HIPAA Public Law 104-191 Code of Federal Regulations at section 45	• **HIPAA is a federal law that regulates disclosure of medical records. Information that must be reported under mandatory reporting laws is governed solely by California law.** • **HIPAA provides that a parent or guardian will be the personal representative of a child and is able to authorize the release of medical records. When the parent is not a personal representative of a child, HIPAA defers to state law to determine who can authorize disclosure of health information and who can be the recipient of health information.** 45 CFR 164.502(g). • **Social welfare agencies, when investigating cases of child abuse, should not be greatly impacted by HIPAA because California law in the area of investigating and reporting child abuse is not preempted by HIPAA.** HIPAA provides for an exception

to federal regulation for the reporting of disease or injury, child abuse, birth, or death, or for public health surveillance, investigation, or intervention and allows for state law to control in this instance. 45 C.F.R. §160.203.

- **Law Enforcement, when investigating cases of child abuse, should not be impacted by HIPAA because California law is not preempted by HIPAA. The following are exceptions in HIPAA created for law enforcement when a criminal case in being investigated.** HIPAA provides for an exception to federal regulation for the reporting of disease or injury, child abuse, birth, or death, or for public health surveillance, investigation, or intervention and allows for state law to control in this instance. 45 C.F.R. §160.203

Law Enforcement/Prosecution Exceptions to HIPAA

Obtaining medical records in criminal cases is currently governed by Penal Code section 1543 (Disclosure of Medical Records to Law Enforcement Agencies), Penal Code section 1524, 45 CFR 164.512/Public Law 104-191 (Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 - *HIPAA*), California Civil Code beginning at section 56; and, mandatory reporting sections pursuant to the Penal Code beginning at section 11160 through 11174.31.

- Medical information will be kept private, and will not be given to law enforcement or prosecutors, unless there is an exception that applies. There are many exceptions that apply to law enforcement. The following chart is intended to define how law enforcement can get medical information during the investigation and prosecution of a criminal case.

EXCEPTION	Statutory Authority and Description

		enforcement pursuant to state mandatory reporting laws under 45 CFR 164.512(b-c)(f) and 45 CFR 160.203(c). In California, Penal Code section 11160 et al. requires that certain crimes be reported to the police when an injured person presents to a medical provider. All child abuse, whether or not there is an injury, must be reported to law enforcement pursuant to Penal Code section 11166 et al. Mandatory reporting is accomplished on specific forms. Law enforcement is entitled to information about injured victims and any person with gunshot or stab wound under mandatory reporting that includes: (1) name of the injured person, injured person's whereabouts, (2) the character and extent of injuries, and (4) the identity of the perpetrator. The law also states that the report shall include these four elements, but is not limited to them. In other words, more can be disclosed by a medical provider in the discretion of the medical provider**.** No subpoena, court order or search warrant is necessary under mandatory reporting. A failure to report crimes subject to mandatory reporting is a misdemeanor.
	As Permitted by a Judicial Officer	45 CFR 164.512(f)(1)(ii)(A) says that law enforcement can get medical records with the following: (1) search warrant, (2) court order, and (3) a judicial subpoena. California law allows prosecutors and police to obtain medical records with a search warrant pursuant to Penal Code section 1524 as long as a "special master" is used during the search to deal with privilege issues. Specific records can obtained by prosecutors and police with a court order and when the court deals with specific privacy concerns before the records are made known under Penal Code section 1543. The procedure requiring a court order under Penal Code section 1543 is usually used after a case is filed by prosecutors.
	Identifying or Locating a Suspect	45 CFR 164.512(f) (2) (i-ii) allows medical providers to give: (1) suspect name and address, (2) DOB and place of birth, (3) SS#, (4) blood type, (5) date and time of death, and (6) distinguishing characteristics.

	Disclosure About a Suspected Crime Victim	Law enforcement should seek to obtain information under the mandatory reporting provisions if they apply (Penal Code sections 11160 and 11166). If mandatory reporting does not apply, then information can only be given with permission of a victim. If the victim is incapacitated, law enforcement must tell the medical provider that there is an emergency, *the information will not be used against the victim*, and that the investigation would be compromised if they waited for consent. 45 CFR 164.512(f) (3) The medical provider has discretion to disclose if they deem it in the best interest of the victim. The information they disclose is the minimum necessary information to accomplish a law enforcement purpose.
	Decedents	Law enforcement should seek to obtain information under the mandatory reporting provisions if they apply. 45 CFR 164.512 allows law enforcement to obtain minimum necessary information to accomplish a law enforcement purpose.
	Crimes on the Premises of the Medical Provider	45 CFR 164.512(f) (5) allows for disclosure of information when a crime occurs on hospital premises.
	Emergency Medical Care Off Premises Example: Paramedics	Use mandatory reporting laws and the law related to identifying and locating a suspect to get the greatest amount of information. Remember that paramedics are subject to HIPAA. 45 CFR 164.512(f)(6) allows for disclosure of the commission and nature of the crime, location of victims, identity, description and location of the perpetrator
	Averting a Serious Threat to Health or Safety	Medical providers may disclose information to prevent or lessen a serious threat to the public and law enforcement *or* information that is critical to identify and apprehend an individual who appears to have escaped from custody or made a statement admitting participation in the commission if a crime involving violence. 45 CFR 164.512(j)
	Administrative Hearings Example: Board of Rights and DMV Hearings	45 CFR 164.512(f) (1) (ii) (C) allows for disclosure that is relevant and material to a legitimate investigation. The request must be specific and

		limited in scope to meet the intended purpose. Finally, if other information would suffice or information can be gotten another way (for example through authorization), it has to be obtained in another manner. California does not have administrative subpoenas.
	Jails and Prisons	Jail and prison hospitals are covered by HIPAA. If a patient is imprisoned, medical information can be shared that protects individuals working in the medical facility and the inmates and to promote law enforcement purposes *within* the facility. Once the inmate leaves the facility, regular privacy rules apply.

The Child Abuse Central Index Penal Code section 11170 *Note:* The recent case of *Humphries v. County of Los Angeles 2008 DJDAR 16564* (November 6, 2008) held that maintenance of the California Child Abuse Central Index violates due process because individuals identified in the index are not given a fair opportunity to challenge their inclusion in the data base in that there is no meaningful opportunity to remove their names or to even clear their names. Users and contributors to the Index should watch for legal developments related to this case in the future.	• **The Child Abuse Central Index is a statewide data base available to a wide range of parties who deal with child abuse.** The index is created by Penal Code section 11170 and can be useful to obtain information about an abused child. The Attorney General's Child Protection Program administers the Child Abuse Central Index. Child abuse investigations are reported to the Child Abuse Central Index. These reports pertain to investigations of alleged physical abuse, sexual abuse, mental/emotional abuse, and/or severe neglect of a child. The reports are submitted by police, sheriff, county welfare and probation departments. To aid law enforcement investigations and prosecutions, the Child Protection Program makes information from the Child Abuse Central Index available, including notices of new child abuse investigation reports involving the same reported suspects and/or victims. Information also is provided to designated social welfare agencies to help screen applicants for licensing or employment in child care facilities and foster homes, and to aid in background checks for other possible child placements, and adoptions. Dissemination of Index information is restricted and controlled by the Penal Code. • **What information can be obtained from the Index?** Information on file in the Child Abuse Central Index include: (1) names and personal descriptors of the suspects and victims listed on reports; (2) reporting agency that investigated the incident; (3) the name and/or number assigned to the case by the investigating agency; (4) type(s) of abuse investigated; and, (5) the findings of the investigation for the incident, which is either substantiated or inconclusive. • **What information is reported to the Index?** Each reporting agency is required by law to forward to DOJ a summary of every child abuse incident it investigates, unless the incident is determined to be unfounded or general neglect. Each reporting agency

	is responsible for the accuracy, completeness and retention of reports submitted. Penal Code section 11169(a) • **Who must report to the Index?** Agencies who must give information to the Index are any police or sheriff's department, not including a school district police or security department, county probation department, if designated by the county to receive mandated reports, or the county welfare department. Penal Code sections, 11169(a) • **Who can access the information?** The Department of Justice shall make available to a law enforcement agency, county welfare department, or county probation department that is conducting a child abuse investigation, relevant information contained in the index. Additionally, medical practitioners, guardian ad litems, counsel for a minor, chairpersons of death review teams, court investigators, any person or entity involved in placing children or who is actively involved with children have access to some information. Penal Code section 11170(b)(3-7)
CWS/CMS – Child Welfare Services/Case Management System Welfare and Institutions Code Section 16501	• **CWS/CMS is a system that is statewide that is used by Child Welfare Offices.** • **Who can access the information?** Child welfare workers can access the system. • **What information is in the system?** Child and family specific information used for the purpose of making appropriate and expeditious case decisions. • **This is an internal system used by Child Welfare Offices.**
CLETS – California Law Enforcement Telecommunications System Penal Code section 11105	• **CLETS is a criminal record system that is maintained by the Department of Justice.** Penal Code section 11105(a)(1). • **What information is in the system?** Arrests and convictions. Penal Code section 11105(m)(2). • **Who can this information be disclosed to?** Law enforcement, prosecutors, defense attorneys, public health officers when they are enforcing 120175 of the Health and Safety Code, local child support enforcement agencies, and, county child welfare agency personnel who have been delegated the authority of county probation officers to access criminal record information used for the purposes described in Welfare and Institutions Code section 16504.5. Penal Code section 11105(b)(1). • **Welfare and Institutions Code section 16504.5 allows the sharing of a criminal record with authorized child welfare workers.** A child welfare agency may secure from an appropriate governmental criminal justice agency the state summary criminal history information in order to conduct a child abuse investigation or an investigation involving a child in which the child is alleged to come within the jurisdiction of the

	juvenile court under Section 300, to assess the appropriateness and safety of placing a child who has been detained or is a dependent of the court, in the home of a relative assessed pursuant to Section 309 or 361.4, or in the home of a non-relative extended family member assessed as described in Section 362.7 during an emergency situation, or to attempt to locate a parent or guardian pursuant to Section 311 of a child who is the subject of dependency court proceedings. Any time that a child welfare agency initiates a criminal background check through the California Law Enforcement Telecommunications System, the agency shall ensure that a state-level fingerprint check is initiated within 10 calendar days of the check, unless the whereabouts of the subject of the check are unknown or the subject of the check refuses to submit to the fingerprint check. The Department of Justice shall provide the requesting agency a copy of all criminal history information regarding an individual that it maintains pursuant to subdivision (b) of Section 11105 of the Penal Code. Criminal justice personnel shall cooperate with requests for criminal history information authorized pursuant to this section and shall provide the information to the requesting entity in a timely manner. Welfare and Institutions Code section 16504.5 (a-b). • **Criminal record information is confidential and it is a crime to disclose it.** Any law enforcement officer or person authorized to receive the information who obtains the information in the record and knowingly provides the information to a person not authorized by law to receive the information is guilty of a misdemeanor as specified in Section 11142 of the Penal Code. Welfare and Institutions Code section 16504.5 (c)