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FAMILY ASSESSMENT AND INVESTIGATION

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FAMILY ASSESSMENT AND INVESTIGATION

4.1 Introduction

The Virginia Administrative Code 22 VAC 40-705-10 defines family assessment and investigation as follows:

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

4. Alternative plans for the child's safety if protective and rehabilitative services are indicated and the family is unable or unwilling to participate in services;
5. Whether or not abuse or neglect has occurred;

6. If abuse or neglect has occurred, who abused or neglected the child; and

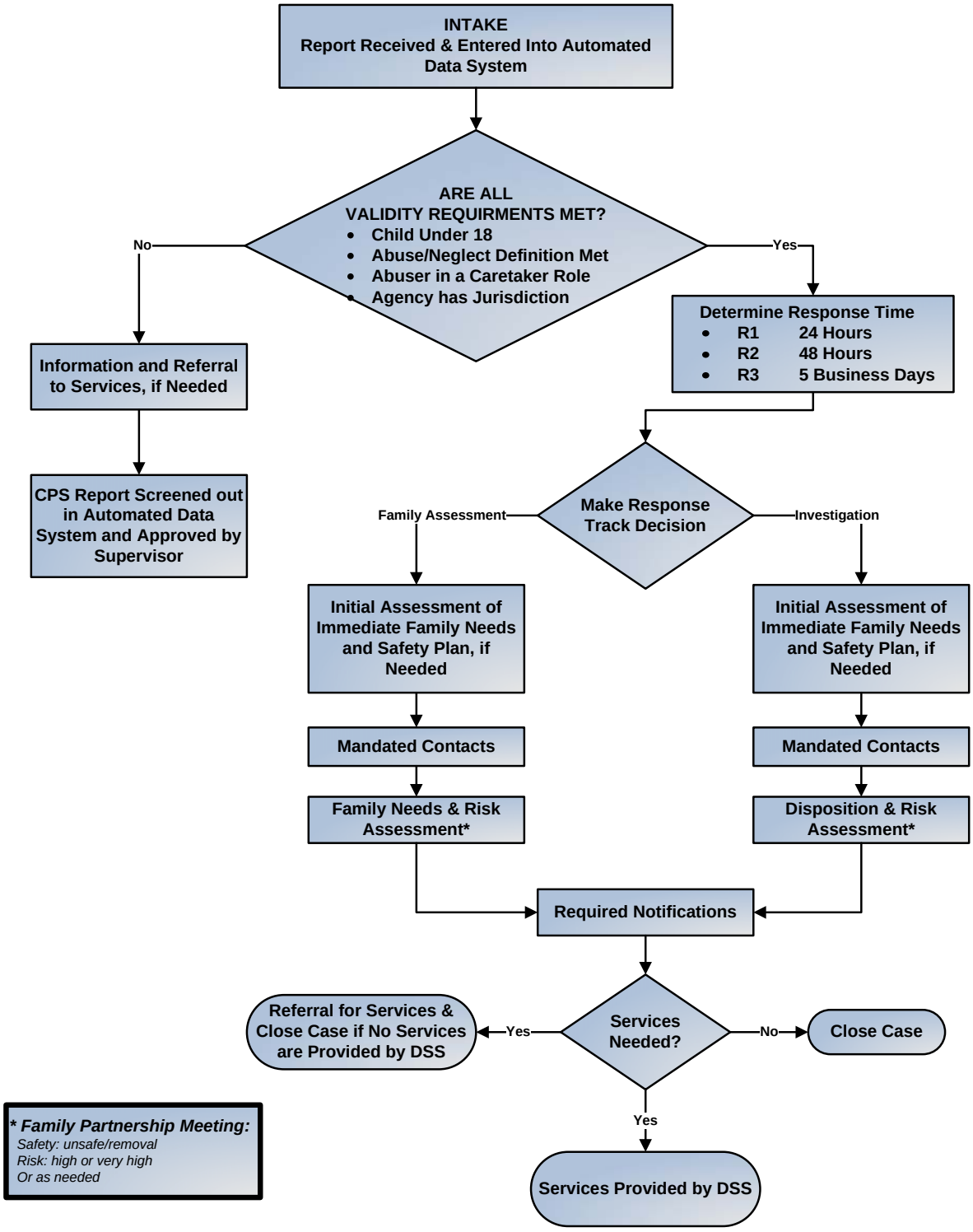
7. A finding of either founded or unfounded based on the facts collected during the investigation.

Every valid report of abuse or neglect shall receive either a family assessment or an investigation. The goals of both responses are to:

- Assess child safety.
- Strengthen and support families.
- Prevent child maltreatment.

The following charts show the CPS Process and Requirements for Family Assessment and Investigation.

CPS Process Chart



CPS REQUIREMENTS FOR FAMILY ASSESSMENT AND INVESTIGATION

CPS REQUIREMENTS	FAMILY ASSESSMENT	INVESTIGATION
Conduct Safety Assessment*	YES	YES
Mandated contacts: • Child & siblings • Alleged Abuser • Parent or Guardian • Collaterals	YES	YES
Other Contacts, if relevant: • Commonwealth attorney – if criminal act is alleged • Medical Examiner – if child fatality • Law Enforcement – if criminal act is alleged and joint response is needed • CPS Regional Specialist –child fatality or certain out of family reports	YES	YES
Observe family environment and/or site where alleged abuse occurred.	YES	YES
Enter the home if allowed to do so by an adult residing in the home.	YES	YES
Notify: • Parent if child interviewed at school or other setting. • Alleged abuser. • Non-custodial parent when that parent is not the subject of a report. • All parties of any extension of timeframe. • All parties when family assessment or investigation is completed.	YES	YES
Refer children under age 3 to Infant and Toddler Connection Program	NO	YES in founded investigations
Complete Family *Risk* Assessment within 45-60 days.	YES	YES
Complete Investigation Dispositional Assessment within 45-60 days	NO	YES
Provide Services if risk is moderate, high, or *very* high* and services are needed for prevention of abuse or neglect.	YES	YES
Document all CPS requirements in automated data system.	YES	YES

May Convene Family Partnership Meeting at appropriate Safety and Risk decision points

4.2 Authorities

The Code of Virginia grants CPS workers the authority to conduct family assessments and investigations in response to a valid report of suspected child abuse or neglect. Generally, the power to enforce the worker's authority lies with the courts. For example, if an individual refuses to allow the worker to conduct the family assessment or refuses to talk to the worker, the worker may file a petition requesting that the court require the individual to cooperate. An individual's refusal to cooperate does not relieve the LDSS of the responsibility to complete the family assessment or investigation because it has been initiated due to a valid report of abuse or neglect. These authorities are applicable only during the conduct of the family assessment or investigation.

4.2.1 Authority to interview the child

> (22 VAC 40-705-60 1). [When responding to valid complaints or reports local departments have the following authority] To talk to any child suspected of being abused and/or neglected, or child's siblings, without the consent of and outside the presence of the parent or other caretaker, as set forth by § 63.2-1518 of the Code of Virginia.

If the CPS worker talks to the child without the parent's or guardian's prior knowledge, the CPS worker must notify the parent or guardian concerning the interview as soon as possible.

4.2.1.1 Parent or guardian refuses to allow child to be interviewed

The worker may consult with local county/city attorney to determine whether to petition the court to request access to the child if denied access.

4.2.1.2 CPS worker may exclude school personnel from interview

If the CPS worker interviews the child at school, the worker may exclude school personnel from the interview in order to protect the family's right to privacy.

4.2.2 Authority to take or arrange for X-rays and photographs of the alleged victim child

> (22 VAC 40-705-60 2). [When responding to valid complaints or reports local departments have the following authority] To take or arrange for photographs and x-rays of a child who is the subject of a complaint without the consent of and outside the presence of the parent or other caretaker, as set forth in § 63.2-1520 of the Code of Virginia.

Photographs may be taken as part of an investigation or family assessment to document the nature and extent of injuries to the child. These photographs cannot be used in lieu of a medical examination.

X-rays of a child may be taken without the consent of the parent or guardian as part of a medical evaluation related to a CPS family assessment or investigation. All photographs or x-rays taken in accordance with the Code of Virginia § 63.2-1520 may be introduced into evidence in any subsequent court hearing. The court can impose any restrictions concerning the confidentiality of the photographs or x-rays.

4.2.2.1 LDSS may seek complete medical examination of the child

> (22 VAC 40-705-60 3d). The local department shall have the authority to have a complete medical examination made of the child including a written medical report and, when appropriate, photographs and x-rays pursuant to § 63.2-1520 of the Code of Virginia.

The Code of Virginia § 63.2-1524 grants authority to the court to order psychological, psychiatric and physical examinations of the child alleged to be abused or neglected or of the child's parents, guardians, caretakers or siblings. If the alleged victim child's parent, caretaker or other legal guardian refuses permission to have a complete medical examination of the child, the LDSS may consult with the county/city attorney to determine whether to seek a court ordered examination of the child.

4.2.2.2 Photographs of the child's environment

The CPS worker must obtain verbal or written consent from the parent or guardian of the child prior to taking any photographs of the child's environment. Without the consent of parents or guardians, any photographs should only be taken under the direction and supervision of the Commonwealth's Attorney, or the city or county attorney for the LDSS.

Photographs may be taken to clarify statements made by witnesses, to document the circumstances surrounding the alleged abuse or neglect, to depict the environment where the alleged abuse or neglect occurred, and for any other legitimate purpose.[1]

4.2.3 Authority to remove a child

The Code of Virginia § 63.2-1517 provides that a child may be taken into emergency custody when the circumstances present an imminent danger to the child's life or

[1] *Campbell v. Commonwealth*, 405 S.E.2d 1 (Va. Ct. App. 1991) ("A picture can speak a thousand words, and these do."); *Diehl v. Commonwealth*, 9 Va. App. 191, 385 S.E.2d 228, (1989); *Kelly v. Commonwealth*, 8 Va. App 359, 382 S.E.2d 270 (1989).

health to the extent that severe or irremediable injury would likely result before a hearing could be held and a court order was not immediately obtainable. The Code of Virginia § 63.2-1517 also allows a physician, a child protective services worker, or a law-enforcement officer to assume custody of a child when the evidence of the abuse is perishable or subject to deterioration before a court hearing can be held.[2]

> (22 VAC 40-705-60 3). [When responding to valid complaints or reports local departments have the following authorities:] To take a child into custody on an emergency removal for up to 72-96 hours under such circumstances as set forth in § 63.2-1517 of the Code of Virginia.

4.2.3.1 Persons who may take a child into custody

The following persons may take a child into custody for 72-96 hours without prior approval of the child's parents or guardian:

- A physician;
- A child protective service worker; or
- A law enforcement officer when he is investigating a complaint of child abuse or neglect.

4.2.3.2 Mandatory consultation with supervisor prior to removing child

> (22 VAC 40-705-60 3a). A child protective services (CPS) worker planning to take a child into 72-96 hours emergency custody shall first consult with a supervisor. However, this requirement shall not delay action on the CPS worker's part if a supervisor cannot be contacted and the situation requires immediate action.

4.2.3.3 Immunity from liability

> (22 VAC 40-705-60 3c). Any person who takes a child into custody pursuant to § 63.2-1517 of the Code of Virginia, shall be immune from any civil or criminal liability in connection therewith, unless it is proven that such person acted in bad faith or with malicious intent.

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[2] Prior to the 1998 General Assembly, § 63.2-1517 of the Virginia Code specified certain circumstances that must exist for a child to be taken into custody by a physician, a child protective services worker or law-enforcement officer. The 1998 General Assembly amended § 63.2-1517 of the Virginia Code by incorporating language allowing a physician, a child protective services workers or a law-enforcement officer to assume custody of a child when the evidence of the abuse is perishable or subject to deterioration before a court hearing can be held.

4.2.3.4 Emergency removal requirements

These requirements apply to emergency removal of a child during a CPS family assessment or investigation. LDSS may consult with the county or city attorney to ensure these removals are conducted according to the Code of Virginia.

4.2.3.4.1 Exigent circumstances exist

The Code of Virginia § 63.2-1517 requires that exigent circumstances exist for emergency removal of a child from the custody of his parent or guardian.

"Exigent circumstances" means a situation that demands immediate action. The following circumstances must exist to remove a child without prior approval of the parent or guardian:

- The circumstances of the child are such that continuing in his place of residence or in the care or custody of the parent, guardian, custodian or other person responsible for his care, presents an imminent danger to the child's life or health to the extent that severe or irremediable injury would be likely to result before a hearing can be held.
- A court order is not immediately obtainable.
- The court has set up procedures for placing children taken into immediate custody.

4.2.3.4.2 Notifications and written reports if child is taken into emergency custody by CPS

If a child is taken into emergency custody pursuant to the Code of Virginia § 63.2-1517, the service worker, physician, or law enforcement officer shall:

- Notify the child's parents or guardians as soon as possible that the child is in custody.
- Make a written report to the LDSS.
- Notify the court as soon as possible but **in no event more than 72-96 hours** the child is in custody depending on the court's availability.
- File the petition for an emergency removal order **within four (4) hours** of taking custody of the child, or state the reasons for not filing within four hours in the affidavit or sworn testimony.

4.2.3.4.3 Information to be obtained when child is taken into emergency custody by CPS

The LDSS must obtain as much of the following information as possible for purposes of filing a petition:

- The name of the person who assumed emergency custody, his or her professional capacity and the telephone number where he or she can be reached.
- The child's name and birth date.
- Names of parents or guardians.
- Present or last known address of parents or guardians.
- Description of the child's condition in as much detail as possible.
- Any information known concerning the circumstances of the suspected abuse or neglect, including the petitioner's name and the nature of the complaint.
- The specific time and date emergency custody was taken.
- Reason(s) why services to prevent the need for removal were not successful or could not be delivered.

4.2.3.5 Placement requirements when CPS has assumed emergency custody of the child

The LDSS shall ensure that the child is placed in an appropriate emergency, temporary, or permanent setting which will assure the child's safety. If the child is placed in an agency-approved placement, the CPS worker should consult with the agency's foster care or foster home staff.

The following procedures shall be followed prior to placing the child.

- **Supervisory consultation to determine placement**. The child's safety is the primary consideration in deciding whether to place the child on an emergency basis with a relative, neighbor, or friend. The CPS worker in consultation with a supervisor makes a decision to place the child in the home of a relative, neighbor, or friend that is not an agency approved provider. The decision is based on the child's best interest and the appropriate local agency procedures are followed to make the placement.

- **Required background checks on individuals with whom an agency may place a child on an emergency basis**. If the CPS worker is considering a placement with a person that is not an agency approved provider, the Code of Virginia § 63.2-901.1 B requires CPS central registry checks and a written statement of affirmation disclosing any child abuse and neglect and criminal history in Virginia and any other state of residence in the past five years for each adult in the home. The CPS worker, in consultation with a supervisor, shall evaluate and document in the automated data system the results of the CPS central registry searches on every adult household member with whom the agency is considering placing the child. The Sworn Statement of Affirmation form is available on the DSS internal website.

  It is the CPS worker's responsibility to complete both the central registry search and state police criminal background check as soon as possible.

  For further guidance on emergency placements refer to the Virginia Department of Social Services Foster Care Manual, Section 4, which is available on the DSS internal website.

  The worker and supervisor may also refer to the Virginia Department of Social Services Local Department Resource, Foster and Adoptive Family Home Approval Guidance Manual, which is available on the DSS internal website. The manual is also available on the DSS public website.

- **Post-emergency placement procedures**. The Code of Virginia § 63.2-901.1 establishes that additional searches or procedures are required if the child is to remain in the emergency non-agency approved placement for more than three days. CPS workers should consult with agency foster care or foster home staff to ensure these requirements are met if the child is to remain in the emergency placement for longer than three days. The worker may refer to the DSS Office of Background Investigations for additional information regarding criminal background checks.

- **Convene family partnership meeting around emergency removal**. The LDSS should schedule a family partnership meeting when the worker assesses the child's safety to be in jeopardy or at risk of removal or out of home placement. However, safety concerns are paramount and necessary action to address safety issues shall not be delayed. The family partnership meeting should be scheduled **within 24 hours** after safety issues have been identified and the agency is considering removal, and occur before the five-day court hearing in cases after the emergency removal. Emergency removal prompts the need to convene a family partnership meeting. This meeting provides the opportunity for

family and community participation in the decision-making process for the child. The purpose of the meeting is to facilitate planning to determine whether:

- The agency should file for custody and facilitate placement;
- The child can remain home safely with services, or the child return safely home with services; or
- There will be voluntary placement of the child by parents with provision of services and a safety plan.

The CPS worker should conduct the face to face interview with the alleged victim child and the parent/caretaker prior to the family partnership meeting since the purpose of the meeting is not to interview caretakers, alleged victims, or other collaterals.

The worker and supervisor should discuss the convening and timing of a family partnership meeting at this critical decision point. All family partnership meetings must be documented in the automated data system. For guidance on family partnership meetings please refer to the Family Engagement manual on the sites below.

DSS internal website

DSS public website

- Notification to relatives. **Within 30 days** after removing a child from the custody of the parent/guardian(s), the LDSS shall provide written notice to all grandparents and other adult relatives that the child is being removed or has been removed from the custody of the parent/guardian(s). The purpose of this notice is to explain options the relative has to participate in the care and placement of the child in an effort to establish permanency for the child. The LDSS may determine it is not in the child's best interest to notify relatives involved in family or domestic violence or who are listed on the Virginia State Police Sex Offender Registry. A copy of the written communication shall be kept in the record, and a notation of the agency send date and relative response date, if any, must be recorded in the automated data system. For additional guidance on notification of relatives refer to the Virginia Department of Social Services Foster Care Manual, Section 4, on the DSS internal website.

4.2.3.6 Authority to obtain immediate medical or surgical treatment for child

The Virginia Administrative Code explains the Code of Virginia § 54.1-2969 granting this authority.

> (22 VAC 40-705-60 3e). When a child in 72-96 hour custody is in need of immediate medical or surgical treatment, the local director of social services or his designee(s) may consent to such treatment when the parent does not provide consent and a court order is not immediately obtainable.

When an LDSS has assumed custody of a child and that child is in need of immediate medical or surgical treatment, the LDSS must take the following actions as listed below:

- If a child is in need of immediate medical treatment and the parent is unwilling or unable to consent, the LDSS should first attempt to obtain a court order for treatment.
- If a court order is not immediately obtainable, authority to consent to surgical or medical treatment, tantamount with that of a parent, is confirmed upon the local director of the LDSS, or that person's designee.

4.2.3.6.1 Local director may designate certain persons to provide consent

The local director may designate no more than two persons to act on his or her behalf in authorizing surgical or medical treatment. Those persons must be chosen from:

- Assistant director;
- Casework supervisor;
- Senior service worker; or
- Service worker.

4.2.3.6.2 Parents or guardians of child shall be notified as soon as practicable

Any authorized person who consents to emergency surgical or medical treatment of a child shall make every reasonable effort to notify the child's parent or guardian as soon as practicable.

4.2.3.6.3 Establish protocol with local hospitals for obtaining consent

Each LDSS should establish protocol with local hospitals for obtaining consent when surgical and medical treatment is necessary for a child under emergency custody. This agreement should include:

- A list of persons who may sign the consent form.
- A statement that the parents or guardians of the child refuse to give consent or are unavailable to give consent.
- A statement that a court order for such treatment is not immediately obtainable.
- A statement from the attending physician as to what treatment is necessary.

4.2.3.6.4 Payment for surgical and medical treatment

The LDSS should attempt to obtain payment for surgical or medical treatment from the child's parents, or the child's legal guardians if appropriate. If the parents or legal guardians are unable to pay for the treatment, the LDSS shall explore the possibility that the child may be eligible for Medicaid, Medicare, or other funding.

4.2.3.6.5 LDSS cannot provide consent if child is not in custody

> (22 VAC 40-705-60 3f). When a child is not in the local department's custody, the local department cannot consent to medical or surgical treatment of the child.

4.3 Related responsibilities to conduct family assessment and investigation

4.3.1 CPS worker may enter the home

> (22 VAC 40-705-90 A). In conducting a family assessment or an investigation, the child protective services (CPS) worker may enter the home if permitted to enter by an adult person who resides in the home. Only in those instances where the CPS worker has probable cause to believe that the life or health of the child would be seriously endangered within the time it would take to obtain a court order or the assistance of a law enforcement officer, may a CPS worker enter the home without permission. A child protective services worker shall document in detail in the record and discuss with supervisory personnel the basis for the decision to enter the house without permission.

4.3.1.1 Entering the home

When conducting a family assessment or an investigation, the CPS worker should explain the purpose of the visit and enter the home when allowed to do so by an adult who resides in the home.

4.3.1.2 CPS worker may enter home without permission if there is probable cause to believe exigent circumstances exist

The worker cannot enter the home without permission unless there is probable cause to believe that the circumstances are such that the life or health of the child would be seriously endangered within the time it would take to obtain a court order or the assistance of a police officer.

The assistance of a police officer does not, in and of itself, provide the authority for a service worker to enter the home without permission. There must be probable cause to believe that "exigent circumstances" exist.

"Probable cause" means the reasonable belief in the existence of facts on which the complaint is based.[3] "Exigent circumstances" means situations that demand unusual or immediate action. They are emergency-like circumstances in which the service worker must act immediately to protect the safety of a child or preserve the evidence in an investigation. [4]

4.3.1.3 CPS worker shall consult with supervisor and document decision to enter a home without permission

If the circumstances are such that the CPS worker must enter the home without permission of an adult residing in the home, the CPS worker shall record in the automated data system the reason for this action. The CPS worker shall consult with a supervisor to make this decision.

4.3.1.4 Adult residing in home refuses to allow CPS worker to enter a home

If a person residing in the home refuses to allow the CPS worker into the home and there are no exigent circumstances demanding that the CPS worker act immediately, the CPS worker must consider alternate plans such as seeking court assistance to gain access to the home. The CPS worker may consult with county/city attorney to determine if court intervention is appropriate. For a further discussion of alternatives to entering the home when permission is denied, see Appendix B.

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[3] Black's Law Dictionary 1321 (9th ed. 2009).

[4] Black's Law Dictionary 277 (9th ed. 2009).

4.3.1.4.1 Exception: Conducting joint investigation with law enforcement

If, during a joint investigation, a law-enforcement officer or the Commonwealth's Attorney Office objects to the CPS worker informing the person of his right to refuse entry, the LDSS should consider that objection as an exception to 22 VAC 40-705-90 A.

The objection is only valid during a joint investigation with law enforcement when the investigation involves criminal charges. The objection must be premised upon not compromising the criminal investigation. The CPS worker shall document the objection in the automated data system.

4.3.2 Transport children

> (22 VAC 40-705-90 C). The child protective services worker may transport a child without parental consent only when the local department has assumed custody of that child by virtue of 72-96 hour removal authority pursuant to § 63.2-1517 of the Code of Virginia, by an emergency removal court order pursuant to § 16.1-251 of the Code of Virginia, or by a preliminary removal order pursuant to § 16.1-252 of the Code of Virginia.

4.3.3 CPS worker may request alleged abuser or neglector to consent to substance abuse screening

> (22 VAC 40-705-90 D). When a child protective services worker has reason to believe that the caretaker in a valid report of child abuse or neglect is abusing substances and such behavior may be related to the matter being investigated or assessed, the worker may request that person to consent to substance abuse screening or may petition the court to order such screening.

4.3.3.1 LDSS must develop substance abuse guidelines

> (22 VAC 40-705-90 D1). Local departments must develop guidelines for such screening.
>
> (22 VAC 40-705-90 D2). Guidelines may include child protective services worker administration of urine screening.

The LDSS should seek the assistance of the Commonwealth's Attorney Office, the local city or county attorney, or the court to develop these guidelines.

4.3.4 Reasonable diligence

The Code of Virginia § 63.2-1503 F mandates the LDSS to use reasonable diligence in locating the subjects of a report or complaint of abuse or neglect.

> (22 VAC 40-705-50 H3). The local department shall use reasonable diligence to locate any child for whom a report or complaint of suspected child abuse and/or neglect has been received and determined valid or persons who are the subject of a valid report if the whereabouts of such persons are unknown to the local department, pursuant to § 63.2-1503 F of the Code of Virginia.

4.3.4.1 Document use of reasonable diligence in locating child and family

> (22 VAC 40-705-50 H4). The local department shall document its attempts to locate the child and family.

The LDSS shall document in the automated information system all attempts to locate the alleged victim child and the family.

4.3.4.2 Use of reasonable diligence in locating alleged victim child

The Code of Virginia § 63.2-1503 F requires the LDSS to use reasonable diligence to locate children for whom a report of suspected child abuse and/or neglect has been received and is receiving a family assessment or investigation.

4.3.4.3 Reasonable diligence shall be used to locate subjects of the family assessment or investigation

Reasonable diligence shall also be used by the LDSS to locate persons who are the subject of a child protective services (CPS) family assessment or investigation, if the whereabouts of such persons are unknown to the LDSS.

4.3.4.4 Subjects of the family assessment or investigation

The subjects of the family assessment or investigation include:

- Any child for whom a report of suspected abuse or neglect has been received and is under investigation.
- Persons named as the alleged abuser and/or neglector of a report that is under investigation.

4.3.4.5 What constitutes reasonable diligence

The LDSS shall document reasonable and prompt attempts to locate the child and family including checking the following, when applicable:

- CPS Automated Data System.
- Postal Service for last known address.
- Postal Service for forwarding address.
- Neighbors, landlords, known relatives.
- School records.
- Department of Motor Vehicles.
- Department's Division of Support Enforcement.
- Department of Corrections, Probation and Parole.
- Law Enforcement.
- Telephone and utility companies.
- Employer.
- Other appropriate contacts.

The LDSS must document in the automated information system all attempts to locate the child and family and the results of the attempts.

4.3.4.6 When the alleged victim child is not found

> (22 VAC 40-705-50 H5). In the event the alleged victim child or children cannot be found, the time the child cannot be found shall not be computed as part of the 45-60 day time frame to complete the investigation, pursuant to subdivision 5 of § 63.2-1505 B5 of the Code of Virginia.

When the alleged victim child cannot be located, despite the LDSS's efforts, the 45-60 day time frame for completing the investigation or family assessment will be suspended. The LDSS must document the suspension in the automated data system and the reasoning for the suspension.

4.3.4.7 LDSS must notify automated data system

When the alleged victim child is not located, the LDSS must notify the automated data system that the family assessment or investigation is suspended and pending.

4.3.4.8 LDSS must continue periodic checks for missing child

If the alleged victim child is not found, the LDSS must establish a timetable for making periodic checks for the missing child. The LDSS shall document the timetable in the case record and the results of the periodic checks. Periodic checks for the missing child must continue until the LDSS is satisfied with the resolution of the referral. The LDSS must notify the automated data system and document in the record the resolution of the referral.

4.3.4.9 If missing child is found

If a family assessment or an investigation was suspended and the missing child is subsequently located, the LDSS must resume the assessment or investigation of the original complaint or report and update the automated data system. Upon locating the missing child, a new 45-day time frame will commence.

4.3.4.10 Identifying relatives and family supports

During the course of the investigation or family assessment, the worker should gather information to identify maternal and paternal relatives and the kinship network providing support and resources to the family and child. Many families identify non-relatives as kin, such as godparents, friends, and others with whom they have a family-like relationship. The early identification of adult family members and supports is critical for initial assessments when identifying protective factors, strengths, and needs. When appropriate, these individuals may become resources in protective interventions, family partnership meetings, and case planning during the CPS process or any future case involvement. Resources and Tools for Diligent Family Search and Engagement are available on the Children's Services System Transformation website.

4.4 Time frames to complete family assessments and investigations

4.4.1 Complete family assessment and investigation in 45 calendar days

The Code of Virginia § 63.2-1506 B3 requires the LDSS to complete and document the family assessment and investigation within 45 calendar days of receipt of the complaint or report.

4.4.2 Fifteen-day extension to complete family assessment and investigation

> (22 VAC 40-705-120 A). The local department shall promptly notify the alleged abuser and/or neglector and the alleged victim's parents or guardians of any extension of the deadline for the completion of the family assessment or investigation pursuant to § 63.2-1506 B3 or subdivision 5 of § 63.2-1505 of the Code of Virginia. The child protective services worker shall document the notifications and the reason for the need for additional time in the case record.

Upon written justification by the LDSS, based on locally determined guidelines, the family assessment or investigation can be extended for 15 calendar days.

The notification to the alleged abuser/neglector should include a brief explanation of the reason for the extension. If written notification is made, a copy of the notification must be included in the LDSS's record. If notification is made verbally, then the LDSS must document the notification in the automated data system. The LDSS must document the justification in the automated data system for the additional time needed to complete the family assessment or investigation.

4.5 Notify family of family assessment or investigation

The Virginia Administration Code 22 VAC 40-705-90 B requires the CPS worker to explain the CPS Family Assessment or Investigation process to the alleged abuser or neglector.

> (22 VAC 40-705-90 B). Before conducting a family assessment or investigation, the child protective services worker shall explain the responsibilities and authorities of CPS so that the parent or other caretaker can be made aware of the possible benefits and consequences of completing the family assessment or investigation. The explanation must be provided orally and in writing.

The CPS worker must notify the family in writing and orally that a report of suspected abuse or neglect has been received and that a family assessment or an investigation will be conducted in response to the report. The written notification is one of the following brochures:

- "Child Protective Services: A Guide to Family Assessment"
- "Child Protective Services: A Guide to Investigative Procedures"

4.5.1 Notify non-custodial parent

Pursuant to § 63.2-1503 O of the Code of Virginia, the LDSS shall make reasonable efforts to notify the non-custodial parent when that parent is not the subject of the child abuse or neglect report. Not only does the non-custodial parent have a right to know about the report involving his/her child, that parent may be a resource to the child and should be invited to any family partnership meeting scheduled. However, if there is reason to believe that such notification would be detrimental to the child, the LDSS may take that concern into account. The response to the report should not be delayed if the non-custodial parent is unreasonably difficult to contact. The LDSS should document all reasonable efforts to locate and notify the non-custodial parent about the report. Conversely, the LDSS should document why reasonable efforts were not made to notify the non-custodial parent.

4.6 Conduct initial safety assessment and develop safety plan in family assessment and investigation

> (22 VAC 40-705-110 A). In both family assessments and investigations the child protective services worker shall conduct an initial assessment of the child's circumstances and threat of danger or harm, and where appropriate shall make a safety plan to provide for the protection of the child.

An initial safety assessment is conducted at the beginning of a family assessment or investigation. The purpose of the initial safety assessment and safety plan is to:

- Assess whether any children are currently in immediate danger of serious physical harm that may require a protecting intervention.
- Determine what interventions should be maintained or initiated to provide appropriate protection.

Safety Assessments differ from Risk Assessments in that the purpose is to assess a child's present or immediate danger and the interventions currently needed to protect the child. In contrast, Risk Assessment evaluates the likelihood of future maltreatment.

4.6.1 Immediate child safety and family needs

Safety assessment is both a process and a document. Safety must be determined for each child and the safety conclusion based on the least safe child if there is more than one child in the family. To ensure that the safety of the child is appropriately assessed in each family assessment and investigation, the LDSS must complete *the process of* an initial safety assessment *within 24 hours of* the first meaningful contact

with the family *and any time safety changes* and document the results in the *CPS Safety Assessment Tool in* the automated data system *within 3 working days*. *For accurate completion, it is critical to refer to the definitions provided on the Safety Assessment Tool, and decisions must be based on supporting narrative documented in the automated data system. The Safety Assessment Tool with definitions is located in* Appendix D *and on the* CPS forms page *on the DSS internal website.*

The Safety Assessment Tool provides structured questions concerning the danger of immediate harm or maltreatment to a child. This information guides the decision about whether the child may remain in the home with no intervention, may remain in the home with safety interventions in place, or must be removed from the home. This is an appropriate time for the LDSS to consider convening a family partnership meeting if necessary to address ongoing safety planning.

For example, a 3-year-old child may be more vulnerable and more threatened with severe harm by an out-of-control parent than a 13-year-old, but even the 3-year-old may be deemed safe if the parent has just been taken away by the police and a responsible adult is available – so there is no severe nor imminent threat of harm to the vulnerable child.

4.6.1.1 Assess immediate danger to the child

The initial safety assessment focuses on the child and the child's immediate needs. Factors to consider when assessing the immediate situation of the child include:

- Whether the child has sustained a mental or physical injury warranting immediate attention or care.
- Whether an emergency or crisis situation exists meriting immediate action to protect the child.
- Whether the child is at risk of serious abuse or neglect in the near future.

4.6.1.2 Assess immediate needs of the family

After assessing the immediate safety needs of the child, the worker must evaluate the immediate needs of the family. Factors to consider include:

- If the child has been injured or harmed, whether the family has the capabilities or capacity to protect the child from further harm.
- Whether an emergency or crisis situation exists and the family's ability to cope.
- Whether any other family members are at risk of harm or danger.

- What are the family's capabilities to ensure the safety of the child or children in the near future?

4.6.1.3 Domestic violence and substance abuse as safety and/or risk assessment issues

Two family issues that can have a major impact on safety and risk are domestic violence and drug and/or alcohol involvement by the child's caretakers.

LDSS are required to develop guidelines for evaluating substance or drug abuse. The CAGEAID tool is one tool that provides questions that can be worked into the interviews with the primary caretakers, and a "yes" to any question may indicate a need for an AOD (alcohol or other drug) evaluation in order to complete the risk assessment. A copy of this tool is in Appendix E.

The Domestic Violence INITIAL ASSESSMENT tool could be given to the caretaker to complete or the questions may be asked by the CPS worker. A "yes" answer to these questions may mean the CPS worker should make a referral to a community domestic violence service provider for a more complete assessment of need. A copy of this tool is in Appendix E.

4.6.2 Make safety decision

After safety and protective factors have been assessed *using the Safety Assessment Tool*, the CPS worker must make a decision about the safety of the child(ren) in the home. The safety decision should be made on the basis of the needs of the least safe child in the home, if there is more than one child. One of the following safety decisions must be determined *using the Safety Assessment Tool* and documented in the automated data system and shared with the family.

- **SAFE**. There are no children likely to be in immediate danger of moderate to serious harm at this time. No safety plan is required.

- **CONDITIONALLY SAFE**. Safety interventions are in place and have resolved the unsafe situation for the present time. A safety plan is required to document the interventions.

- **UNSAFE**. Without controlling intervention(s) a child is in immediate danger of serious harm. A court order or safety plan is required to document intervention.

4.6.2.1 Safety decision and family partnership meeting

The LDSS should schedule a family partnership meeting when the worker assesses the child's safety to be in jeopardy or at risk of removal or out of home placement. However, safety concerns are paramount and necessary action to address safety issues shall not be delayed. The family partnership meeting should be scheduled **within 24 hours** after safety issues have been identified and the agency is considering removal, and occur before the five-day court hearing in cases after the emergency removal. Emergency removal prompts the need to convene a family partnership meeting. This meeting provides the opportunity for family and community participation in the decision-making process for the child. The purpose of the meeting is to facilitate planning to determine whether:

- The agency should file for custody and facilitate placement;
- The child can remain home safely with services, or the child may return safely home with services; or
- There will be voluntary placement of the child by parents with provision of services and a safety plan.

The CPS worker should conduct the face-to-face interview with the alleged victim child and the parent/caretaker prior to the family partnership meeting since the purpose of the meeting is not to interview caretakers, victims, or other collaterals.

The worker and supervisor should discuss the convening and timing of a family engagement meeting at this critical decision point. All family partnership meetings must be documented in the automated data system. For guidance on family partnership meetings please refer to the Family Engagement manual located on the websites below:

DSS internal website

DSS public website

4.6.3 Develop safety plan

When the child is determined to be Conditionally Safe or Unsafe, the CPS worker must determine what services or actions need to occur by developing a safety plan. The Virginia Administrative Code 22 VAC 40-705-10 defines safety plan:

> (22 VAC 40-705-10). "Safety plan" means an immediate course of action designed to protect a child from abuse or neglect.

A safety plan must be made to ensure the immediate protection of the child. When possible, the worker needs to develop the safety plan with the cooperation of the child's parent(s) or guardian(s). The CPS worker must determine what actions are necessary to assure the child's immediate safety. If the actions needed to assure the safety of the child cannot be put in place, alternative steps must be taken that can include court intervention. The safety plan and the CPS worker's efforts to develop the safety plan with the family must be documented in the record. A copy of the safety plan shall be left with the caretaker of the child and/or the alleged abuser. A Safety Plan format is located in Appendix F.

Whenever possible, the caretaker(s) should sign the safety plan along with the worker, so that this document can be used as an agreement as to who will do what to prevent harm to the children in the immediate future. Other parties to the agreement, such as service providers, may also sign the form.

4.6.4 Reassessing safety

Safety assessment is both a process and a document. The process of assessing child safety is ongoing throughout the life of the CPS referral and ongoing case as information is gathered with each contact. While the initial safety decision and safety plan are documented in the automated data system, any subsequent changes in safety assessed in referrals or ongoing cases in the following circumstances should be documented *in the Safety Assessment Tool* in the automated data system *within three (3) working days*:

- A change in family circumstances such that one or more safety factors previously present are no longer present;
- A change in information known about the family in that one or more safety factors not present before are present now; or
- A change in ability of safety interventions to mitigate safety factors and require changes to the safety plan.

When safety is reassessed, the safety plan should be reviewed and revised accordingly. A family partnership meeting may be considered if safety concerns escalate.

4.7 Conduct family assessment

> (22 VAC 40-705-70 B). When completing a family assessment, the local department shall gather all relevant information in collaboration with the family, to the degree possible, in order to determine the child and family services needs related to current safety or future risk of harm to the child.

The family assessment is a process of gathering and evaluating information and formulating conclusions regarding family functioning specific to child abuse/neglect, the presenting complaint allegations, and family needs related to child safety and risk of future abuse or neglect.

The family assessment is a child-centered, family-focused, participatory process that is done with the family. The family assessment builds on family strengths. It identifies parental capacities and resources within the family and the community. The process is designed to incorporate parent/caretaker perceptions of child safety, address the presenting complaint, and determine service needs related to potential maltreatment of the child. The family assessment can and should include the active involvement of all members of the family and significant others in the extended family or community, as appropriate.

4.7.1 Mandated contacts for family assessments

> (22 VAC 40-705-80 A1-3). During the course of the family assessment, the child protective services (CPS) worker shall make and record the following contacts and observations.
>
> 1. The child protective services worker shall conduct a face-to-face interview with and observe the alleged victim child and siblings.
>
> 2. The child protective services worker shall conduct a face-to-face interview with the alleged victim child's parents or guardians and/or any caretaker named in the report.
>
> 3. The child protective services worker shall observe the family environment, contact pertinent collaterals, and review pertinent records in consultation with the family.

When it is possible and practical and places no family member in danger, contacts in a family assessment or investigation may be made with the family members together. However, the individual requirements for each contact should be documented in the automated data system.

A family partnership meeting does not fulfill the requirement for any mandated contact interview during a family assessment or investigation as the purpose is not to interview alleged victims, parents/caretakers, and collaterals. The CPS worker

should conduct the face to face interview with the alleged victim child, siblings, and the parent/caretaker prior to any family partnership meeting.

4.7.1.1 Face-to-face interview with the alleged victim child

The CPS worker shall conduct a face-to-face interview with the alleged victim child and should conduct this face-to-face contact within the response priority level assigned. During the interview, the CPS worker should inform the child what will occur during the assessment process. The CPS worker should observe the child and document the child's recollection and perception of the allegations. The CPS worker should note the child's emotional and physical condition (including any injury). The CPS worker should learn about the child's needs and capabilities for the purposes of risk assessment and service planning. The CPS worker shall document all interviews and attempted interviews in the automated data system.

4.7.1.2 Face-to-face interview with siblings

The CPS worker shall interview and observe *minor* siblings *residing in the home* of the alleged victim child in order to determine whether they have experienced abuse or neglect and to more fully evaluate the family strengths and needs.

4.7.1.3 Interview of non-verbal child

In the case of an interview conducted with a non-verbal child, a child protective services worker shall document in detail in the automated data system the observations of the child interacting with his or her family members and environment.

4.7.1.4 Interview with alleged abuser or neglector

> (22 VAC 40-705-80 A2). The child protective services worker shall conduct a face-to-face interview with the alleged victim child's parents or guardians and/or any caretaker named in the report.

The CPS worker shall conduct a face-to-face interview with the alleged abuser or neglector. The alleged abuser or neglector shall be informed of the allegations and the assessment process. The CPS worker shall document the alleged abuser's or neglector's responses and knowledge about the allegations.

For the purposes of risk assessment and service planning, the CPS worker should identify the alleged abuser's or neglector's needs and capabilities. If the alleged abuser or neglector refuses to be interviewed, the CPS worker must

inform the alleged abuser or neglector that the family assessment must be completed to ensure child safety.

4.7.1.5 The family interview

When it is possible, practical, and places no family member in danger, the Family Assessment contacts may be made with the family members together. This type of interview allows the CPS worker to observe interaction among family members that may contribute to the family needs assessment. When a family interview is conducted, the CPS worker must document each of the individual required contacts in the automated data system.

4.7.1.6 Observe family environment

> (22 VAC 40-705-80 A3). The child protective services worker shall observe the family environment…

The CPS worker shall observe the family environment and determine the effect of the environment on the child's safety and the overall family needs related to caring for the children.

4.7.1.7 Interview collaterals

> (22 VAC 40-705-80 A3). [continued]. The child protective services worker shall… contact pertinent collaterals, and review pertinent records in consultation with the family.

As part of the family assessment, the CPS worker may need to contact collaterals to evaluate the circumstances of the alleged abuse or neglect and the needs of the family. The Virginia Administrative Code defines collateral.

> (22 VAC 40-705-10). "Collateral" means person whose personal or professional knowledge may help confirm or rebut the allegations of child abuse and/or neglect or whose involvement may help ensure the safety of the child.

The CPS worker shall contact any collaterals perceived to have pertinent information. The CPS worker may involve collaterals to help ensure the safety of the child. Contact with the child's other caretakers, such as babysitters or day care providers, is encouraged. The CPS worker may make collateral contacts without the family's consent in order to complete a child protective services family assessment, but consent and collaboration with the family is encouraged. The family assessment should be developed mutually with the family to the degree possible.

The CPS worker shall interview non-victim children as collaterals if it is determined that they may have information which would help in determining the finding in the complaint. Such contact should be made with prior consent of the child's parent, guardian, or agency holding custody. If the situation warrants contact with the child prior to such consent being obtained, the parent, guardian, or agency holding custody should be informed as soon as possible after the interview takes place.

4.7.1.8 Other contacts may be required

The CPS worker must contact the local Commonwealth Attorney and law enforcement to report suspected criminal activity.

4.7.2 First meaningful contact

The CPS worker shall document the contacts required by regulation in the automated data system. It is equally important that the worker document reasons why any mandated contacts or observations were not made or completed. For example, if three phone messages were left or two home visits made with no one answering the door, those attempts should be documented in the automated data system.

The first meaningful contact in the family assessment provides pertinent information relevant to the family assessment and the safety of the child and is usually a face-to-face interview with the victim. There could be circumstances in a family assessment where the first meaning contact is with the alleged abuser or collateral. A first meaningful contact could be by telephone.

The first meaningful contact must be documented as such in the automated data system. The CPS worker should confer with a supervisor if there is any doubt about which contact constitutes the first meaningful contact.

4.7.2.1 Changing the initial track from family assessment to investigation

After the referral is accepted as a family assessment, it may be switched to an investigation in very limited circumstances; however, a referral may not be switched from an investigation to a family assessment. If the family assessment has not yet been completed and new information causes the situation to meet the guidelines for an investigation, the family assessment must be closed and an investigation initiated. Refer to the CPS Report Placement Chart in Section 3 for guidance on track decisions. Also, if an emergency removal occurs during a family assessment the family assessment must be closed and an investigation initiated. A new 45-day period begins to complete the investigation process. A referral may not be switched from a family assessment to an investigation simply because of lack of cooperation on the part of the caretaker.

The caretaker's action or inaction that causes the child to be deemed unsafe may result in an action such as petitioning the court for a protective order to increase child safety. Track change decisions must be documented in the automated data system.

4.7.3 Information to be included in family assessment

In developing the case record and the family assessment narrative, the CPS worker must address and document in the automated data system these issues. Each family assessment may have circumstances warranting more or less details and information.

The examples listed under each factor can be used as a guide for the CPS worker to elicit relevant information and identify family needs, strengths, and supports. A comprehensive family assessment should address the family's strengths and needs in four areas, including but not limited to the issues listed:

- **Children**. Age and ability to self-protect; presence of any disability or developmental delay; temperament; responsiveness to caretaker(s); prior history of abuse/neglect.

- **Parent/caretaker**. Physical, emotional, and intellectual status; prior history of abuse/neglect; potential for violence; substance abuse or dependency; domestic violence; neglectful acts or omissions, allegations of abuse/neglect.

- **Environment**. Any hazardous living conditions or positive factors present in the environment.

- **Support Systems**. Informal and formal; available or needed; past and present resource utilization.

- The Family Assessment **Summary** must include the family members' perceptions of the situation, needs and ability to meet those needs or accept services to meet them. It also includes an assessment of the likelihood (risk) of future abuse or neglect.

There are tools in Appendix C that may assist CPS workers in evaluating the impact of possible substance abuse or domestic violence.

The Family Assessment must be documented in the automated data system.

It must include any identified service needs of the family to reduce or prevent child abuse or neglect.

There is a sample Family Service Agreement in Appendix G that can be used to document service needs with the family. As with the Safety Plan, development of an agreement for services should occur mutually with the family to the degree possible, and they should receive a copy of the agreement.

4.7.4 Reassign family assessment to investigation as a result of an emergency removal

> (22 VAC 40-705-60 3b). When circumstances warrant that a child be taken into emergency custody during a family assessment, the report shall be reassigned immediately to an investigation.

At any time before the completion of the family assessment, if circumstances require that emergency custody be taken of one or more children in the family, the alleged abuser shall be notified immediately that the response of the agency has changed from a family assessment to an investigation.

All the requirements of an investigation are in effect and a new 45-day period begins in order to complete the investigation process. A new investigation referral must be entered into the automated data system and the existing family assessment must be closed.

4.7.5 Determine risk level in family assessment

> (22 VAC 40-705-110 B). In all founded cases and in completed family assessments, the child protective services worker shall make a risk assessment to determine whether or not the child is in jeopardy of future abuse and/or neglect and whether or not intervention is necessary to protect the child.

A Family Risk Assessment must be completed in a family assessment.

Based on the information gathered during the family assessment or investigation, the CPS worker must determine the likelihood of any occurrence or recurrence of abuse or neglect by completing a Family Risk Assessment. The Family Risk Assessment does not predict recurrence but assesses whether a family is more or less likely to have an incident of abuse or neglect without intervention by the agency. The Family Risk Assessment is completed based on conditions that exist at the time the incident is reported and investigated as well as prior history of the family. Risk is calculated in the Family Risk Assessment Tool completed in the automated system. The Family Risk Assessment Tool with definitions is located in Appendix H and on the CPS forms page on the DSS internal website. Selections made on the Family Risk Assessment Tool must be based on supporting narrative in the automated data system.

- **Low**. The assessment of risk related factors indicates that the situation can and will be changed, that no additional intervention is necessary, and that the child or other children are at no reasonably assessable risk of abuse or neglect.

- **Moderate**. The assessment of risk related factors indicates that the child or other children are in possible jeopardy, but that a positive change in the situation is likely to occur with minimal intervention.

- **High**. The assessment of risk related factors indicates a likelihood that the child is in jeopardy of abuse or neglect, and that intervention is necessary in order to protect the child or other children.

- ***Very High****. The assessment of risk-related factors indicates a high likelihood that the child is in jeopardy of abuse or neglect, and that intervention is required in order to protect the child or other children.*

Overrides may increase risk one level and require supervisor approval.

4.7.5.1 Risk level guides decision to open a case

When risk is clearly defined and objectively quantified, resources are targeted to higher-risk families because of the greater potential to reduce subsequent maltreatment. The risk level helps inform the decision whether or not to open a case as follows:

Low Risk:	*Close*
Moderate Risk:	*Open to CPS or close*
High Risk:	*Open to CPS*
Very High Risk:	*Open to CPS*

The worker and supervisor should assess the decision to open a case for services and document in the automated data system the decision not to open a case. For more guidance on service planning in a case, refer to Section 6 Services of this manual

4.7.5.2 Risk level determines need to convene family partnership meeting

A family partnership meeting should be scheduled by the LDSS when the worker assesses a child to be at "very high" or "high" risk of abuse and/or neglect and the child is at risk for out-of-home placement in those families who will be or are receiving services. This meeting is scheduled to develop the plan and services to prevent the out-of-home placement and identifies the circumstances under which a removal might be considered. The meeting should convene **within 30 days** of initiating services and prior to the development of the ongoing service plan. The family partnership meeting must be documented in the automated data system. For guidance on conducting the family partnership meeting, refer to the Family Engagement manual on the following websites:

DSS internal website

DSS public website

4.7.6 Supervisor approval required

The CPS worker's supervisor must approve the family assessment in the automated data system. This approval means the supervisor has reviewed the family assessment to determine that all requirements have been met and that the risk assessment conclusion and rationale are appropriate.

4.7.7 Written and oral notification to family to summarize family needs assessment

The CPS worker shall provide written and oral notification to the family that summarizes the family needs assessment, recommendations for services, and the length of time the family's name will remain in the CPS automated data system. It should outline the conclusions of the assessment and any services to be obtained by the family and/or provided to the family. If continuing services are needed, it should be clear who will do what and by when, and what outcome is expected.

4.7.8 Family refuses services

If the family refuses recommended services, the reason for the refusal must also be included in the written notification to the family and in the automated data system.

The Family Service Agreement form in Appendix G can be photocopied and used to record the agreed upon actions by all parties or to note that these services were recommended but not agreed to by the family.

4.7.9 Notifications in family assessments

> (22 VAC 40-705-140 B5). No disposition of founded or unfounded shall be made in a family assessment. At the completion of the family assessment the subject of the report shall be notified orally and in writing of the results of the assessment.

4.7.9.1 Written notification to alleged abuser or neglector

The written notification to the alleged abuser or neglector of the completed family assessment must be in the form of a letter and a copy must be included in the case record. The written notification shall include the outcome of the family assessment including what services if any were recommended, the length of time the family assessment will be retained, and the right to review information about him and/or herself in the record.

4.7.9.2 Verbal notification to alleged abuser or neglector

The verbal notification to the family members of the conclusions of the completed family assessment should explain what needs were identified, what services are available to meet the needs, and how long information on the family assessment will be maintained in the automated data system. The worker must document in the automated data system the date the verbal notification took place or the reason the verbal notification did not occur.

4.7.9.3 Notification to the complainant

> (22 VAC 40-705-140 D3). When a family assessment is completed, the child protective services worker shall notify the complainant, when known, that the complaint was assessed and necessary action taken.

4.7.9.4 Notification to military personnel (Family Advocacy Program)

The Code of Virginia § 63.2-1503 N establishes authority for the LDSS to share CPS information about completed family assessments with family advocacy representatives of the United States Armed Forces.

> (22 VAC 40-720-20 A). Information regarding child protective services reports, complaints, investigations and related services and follow-up may be shared with the appropriate Family Advocacy Program representative of the United States Armed Forces when the local agency determines such release to be in the best interest of the child. Provision of information as addressed in this chapter shall apply to instances where the alleged abuser or neglector is a member (or the spouse of a member) of the United States Armed Forces. In these situations coordination between child protective services and the Family Advocacy Program is intended to facilitate identification, treatment and service provision to the military family.

> (22 VAC 40-705-140 E). Family Advocacy Program. When a family assessment is conducted and the family is determined to be in need of services, the child protective services worker may notify the Family Advocacy Program representative in writing as set forth in 22 VAC 40-720-20.

In completed family assessments with services needed where the alleged abuser or neglector is an active duty member of the United States Armed Forces or the spouse of a member residing in the member's household, the CPS worker shall provide information regarding the family assessment and the recommended services based on risk to the appropriate Family Advocacy Program **within 30 days** of the completion of the Family Assessment. See Section 9, Confidentiality for guidance about disclosure of other information disclosure to military Family Advocacy Programs.

4.7.9.5 Written notification to alleged abuser or neglector that Family Advocacy Program has been informed of family assessment

The military member shall be advised that this information is being provided to the Family Advocacy Program and shall be given a copy of the written notification sent to the Family Advocacy Program representative.

4.8 Conduct investigation

> (22 VAC 40-705-70 A). When conducting an investigation the local department shall seek first-source information about the allegation of child abuse and/or neglect. When applicable, the local department shall include in the case record: police reports; depositions; photographs; physical, medical and psychological reports; and any electronic recordings of interviews.

4.8.1 Mandated contacts in investigation

Mandated contacts to conduct an investigation are similar to the mandated contacts to conduct a family assessment. There are additional requirements related to electronic recording of interviews of the alleged victim and alleged abuser/neglector. The LDSS shall follow these additional requirements.

A family partnership meeting does not fulfill the requirement for any mandated contact interview during a family assessment or investigation as the purpose is not to interview alleged victims, parents/caretakers, and collaterals. The CPS worker should conduct the face to face interview with the alleged victim child, siblings, and the parent/caretaker prior to any family partnership meeting.

4.8.1.1 Document mandated contacts

> (22 VAC 40-705-80 B). During the course of the investigation, the child protective services (CPS) worker shall make and record in writing in the state automated system the following contacts and observations. When any of these contacts or observations is not made, the CPS worker shall record in writing why the specific contact or observation was not made.

The CPS worker shall document the contacts required by regulation in the automated data system. It is equally important that the worker document reasons why any mandated contacts or observations were not made or completed. For example, if three phone messages were left or two home visits made with no one answering the door, those attempts should be documented in the automated data system.

4.8.2 Face-to-face interview with the alleged victim child must be electronically recorded

In 2005, the Virginia Supreme Court of Appeals issued a ruling to affirm the regulatory requirement that victim interviews in an investigation must be electronically recorded according to 22 VAC 40-705-80 or clearly document the specific and detailed reasons for not taping victim interviews as well as the documentation that the decision was made in consultation with a supervisor. A copy of this decision, known as the West Decision, is available on the website of the Virginia Court of Appeals case #2144042.

> (22 VAC 40-705-80 B1). The child protective services worker shall conduct a face-to-face interview with and observation of the alleged victim child and siblings. All interviews with alleged victim children must be electronically recorded …

The CPS worker shall conduct at least one face-to-face interview with the alleged victim child and should conduct this face-to-face contact within the response priority level assigned. During the interview, the CPS worker should inform the child about the investigation and what will occur during the investigation. The CPS worker shall observe the child and document the child's recollection and perception of the allegations. The CPS worker should note the child's emotional and physical condition (including any injury). The CPS worker should learn about the child's needs and capabilities for the purposes of risk assessment and service planning.

Some of this information may be obtained during the CPS worker's observation of victim interviews conducted by other members of the investigative team including, but not limited to, law-enforcement officers, forensic nurses, or physicians. The CPS worker should review any electronically recorded victim interviews to determine if additional interviews are necessary to document the child's allegations to comply with CPS guidance.

A family partnership meeting does not fulfill the requirement for any mandated contact interview during a family assessment or investigation as the purpose is not to interview alleged victims, parents/ caretakers, and collaterals. The CPS worker should conduct the face-to-face interview with the alleged victim child, siblings, and the parent/caretaker prior to any family partnership meeting.

4.8.2.1 Exceptions to electronically taping interviews with the alleged victim child

> (22 VAC 40-705-80 B1). All interviews with alleged victim children must be electronically recorded except when the child protective services worker determines that:
>
> a. The child's safety may be endangered by electronic recording;
>
> b. The age and/or developmental capacity of the child makes electronic recording impractical;
>
> c. A child refuses to participate in the interview if electronic recording occurs; or
>
> d. In the context of a team investigation with law-enforcement personnel, the team or team leader determines that audio taping is not appropriate.
>
> e. The victim provided new information as part of a family assessment and it would be detrimental to re-interview the victim and the child protective services worker provides a detailed narrative of the interview in the investigation record.

The Virginia Administrative Code provides five exceptions to audio or other electronic recording of an interview with an alleged victim child. Before electronically recording an interview with a child, the CPS worker must assess the circumstances surrounding the allegations of abuse or neglect and determine whether any of the five exceptions precluding audio taping the interview apply. Adequately considering the circumstances may include assessing the complaint or report; speaking with the parents or guardians of the child; speaking with collateral witnesses; and conducting an assessment of the child.

The CPS worker shall consult with the supervisor when the decision is made not to electronically record an interview with an alleged victim child. The consultation and the specific reasons why electronic recording is not done in the specific investigation shall be documented in the automated data system.

4.8.2.1.1 Exception: The child's safety may be endangered by electronic recording

If the child's safety is endangered or may be endangered by electronically recording the interview, then the interview must not be electronically recorded. The CPS worker may need to conduct a brief assessment of the child to determine the risk of any harm that may occur to the child as a result of electronically recording the interview. The CPS worker may be able to assess any potential harm to the child by speaking with the child's parents, guardians, or collateral witnesses. If the interview is not electronically recorded, the CPS worker shall carefully document the details of the interview in writing for the case record.

4.8.2.1.2 Exception: The age or developmental capacity of the child makes electronic taping impractical

The CPS worker must assess the mental and physical capacities of the child. The age or development of the child may preclude electronically taping the interview. It may be appropriate to electronically record the questions being asked by the child protective services worker and to describe, either verbally or in writing, the child's responses.

4.8.2.1.3 Exception: The child refuses to participate in the interview if electronic taping occurs

The interview with the child should not be jeopardized because the child refuses to be electronically recorded. If the child refuses to be electronically recorded, the CPS worker should explore the child's reasons and discuss those reasons with the child. If the child still refuses to participate in an electronically taped interview, then the CPS worker must not electronically record the interview. The CPS worker shall document the reasons why the child refused to be electronically recorded.

4.8.2.1.4 Exception: In the context of a team investigation, the team or team leader determines that electronic recording is not appropriate

If a complaint or report of abuse or neglect is being investigated in conjunction with a multidisciplinary team, then the multidisciplinary team should make the decision to electronically record the interview with the alleged victim child based on the specific child and referral. A team investigation includes a joint investigation with the Commonwealth's Attorney office or law enforcement.

4.8.2.1.5 Exception: The victim provided new information as part of a family assessment

If the victim provides new information during a family assessment resulting in an investigation and it would be detrimental to re-interview the victim, the child protective services worker shall provide a detailed narrative of the interview in the investigation record and document this exception to electronically recording the victim interview.

4.8.2.2 Each interview with the alleged victim child must be electronically recorded

Each interview with the alleged victim child must be electronically recorded unless one of the above mentioned exceptions to electronically recording the interview applies. When an interview is not electronically recorded for any reason, the CPS worker shall complete a detailed summary of the interview, including the reasons for not recording the interview and the supervisory consultation for this decision and enter the information into the automated case record.

4.8.2.3 Notify the child's parents or caretakers that interview was electronically recorded

While there is no provision in the Code of Virginia or the Virginia Administrative Code that requires an LDSS to inform the child's parents that the interview was electronically recorded, the LDSS should notify the parents or guardians of the alleged victim child about the interview and that the interview was electronically recorded.

The LDSS should explain to the parents or guardians that the Code of Virginia allows the CPS worker to interview the alleged victim child without the consent of the parents and the Virginia Administrative Code requires the interview to be electronically recorded.[5]

4.8.2.4 Parents or caretakers object to electronically recorded interview

There is no provision in the Virginia Administrative Code allowing an exception to electronic recording when the parents or guardians object to the LDSS electronic recording the interview of the alleged victim child. The CPS worker should explore the foundation for the parents' objection. The objection to the electronic recording may satisfy one of the enumerated exceptions to electronic recording.

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5 VA Code § 63.2-1518 provides any person required to make a report of abuse or neglect with the authority to talk to a child suspected of being abused or neglected outside the presence of the child's parents, guardian, other person standing in loco parentis or school personnel. 22 VAC 40-705-80 B requires that any interview by a CPS worker with an alleged victim child be audio taped recorded.

4.8.2.5 Equipment malfunction

22 VAC 40-705-80 B1 provides that a CPS finding may be based on the written narrative should equipment failure occur. If an interview of an alleged victim child is not electronically recorded because of equipment malfunction, then the CPS worker shall write a detailed narrative of the interview and include that narrative in the record.

4.8.3 Interview with child's parents or guardians

> (22 VAC 40-705-80 B3). The child protective services worker shall conduct a face-to-face interview with the alleged victim child's parents or guardians.

The CPS worker shall conduct a face-to-face interview with the child's parents or guardians to obtain information about the child and about the parents' or guardians' knowledge of the allegations. The CPS worker should inform the parents or guardians about the investigative process and provide sufficient information to involve them in planning and support for the child.

4.8.4 Face-to-face interview with alleged abuser or neglector

> (22 VAC 40-705-80 B2). The child protective services (CPS) worker shall conduct a face-to-face interview with the alleged abuser and/or neglector.

The CPS worker shall conduct a face-to-face interview with the alleged abuser or neglector. The CPS worker shall inform the alleged abuser or neglector of the allegations and the investigative process. The CPS worker must document the alleged abuser or neglector responses about the allegations. If the alleged abuser or neglector refuses to be interviewed, the CPS worker must inform the alleged abuser or neglector that the investigation must continue and a disposition will be made.

4.8.4.1 Inform alleged abuser or neglector of right to electronically record interview

> (22 VAC 40-705-80 B2a). The CPS worker shall inform the alleged abuser and/or neglector of his right to tape record any communication pursuant to § 63.2-1516 of the Code of Virginia.

4.8.4.1.1 Law enforcement or Commonwealth's Attorney objects to informing the alleged abuser or neglector of his right to audio record the interview

A law-enforcement officer or the Commonwealth's Attorney may object to the LDSS informing the alleged perpetrator of his right to electronically record an interview. If a law-enforcement officer or a Commonwealth's Attorney objects, then the LDSS shall not advise the alleged perpetrator of

that right. This objection applies when the Commonwealth's Attorney or the law-enforcement officer believes that the instruction will compromise the investigation of any criminal charges.

This objection must be documented in the automated data system.

4.8.4.2 LDSS shall provide recording equipment upon request

> (22 VAC 40-705-80 B2b). If requested by the alleged abuser and/or neglector the local department shall provide the necessary equipment in order to tape record the interview and retain a copy of the tape for the record.

The CPS worker must be prepared to provide the equipment should the alleged abuser or neglector elect to electronically record the interview. The LDSS must provide a copy of the electronically recorded interview to the alleged abuser or neglector upon request.

4.8.4.3 Miranda rights

The Code of Virginia § 63.2-1503 M provides that statements made by the alleged abuser or neglector to the investigating CPS worker after the alleged abuser or neglector has been arrested are not admissible in any criminal proceedings unless the alleged abuser or neglector was advised of his rights against self-incrimination. If a person suspected of abuse or neglect is arrested, that person must be advised of his rights against self-incrimination or any subsequent statements made by the person cannot be used during the criminal proceedings. This section of the Code of Virginia only pertains to the admissibility in criminal proceedings of statements made by the alleged abuser or neglector after that person has been arrested. This section of the Code of Virginia does not pertain to the use of any statements made by the alleged abuser or neglector in determining whether the complaint or report is founded or unfounded. While certain statements made by the alleged abuser or neglector may not be admissible in a court of law, there is no specific exclusion to the LDSS using those statements in determining a founded or unfounded disposition.

4.8.4.4 May obtain and consider criminal history record for alleged abuser and all adult household members

> (22 VAC 40-705-80 B7). Pursuant to § 63.2-1505 of the Code of Virginia, local departments may obtain and consider statewide criminal history record information from the Central Criminal Records Exchange on any individual who is the subject of a child abuse and neglect investigation where there is evidence of child abuse or neglect and the local department is evaluating the safety of the home and whether removal is necessary to ensure the child's safety. The local department may also

> obtain a criminal record check on all adult household members residing in the home of the alleged abuser and/or neglector and where the child visits. Pursuant to § 19.2-389 of the Code of Virginia, local departments are authorized to receive criminal history information on the person who is the subject of the investigation as well as other adult members of the household for the purposes in § 63.2-1505 of the Code of Virginia. The results of the criminal record history search may be admitted into evidence if a child abuse or neglect petition is filed in connection with the child's removal. Local departments are prohibited from dissemination of this information excepted as authorized by the Code of Virginia.

4.8.5 Face-to-face interview with siblings

The CPS worker shall interview or observe *minor* siblings *residing in the home* of the alleged victim child in order to determine whether they have experienced abuse or neglect and to more fully evaluate the family strengths and needs.

4.8.6 Observe environment where child lives and visit the site where the alleged abuse or neglect occurred

> (22 VAC 40-705-80 B4). The child protective services worker shall observe the environment where the alleged victim child lives.
>
> (22 VAC 40-705-80 B5). The child protective services worker shall observe the site where the alleged incident took place.

4.8.7 Interview collaterals

> (22 VAC 40-705-80 B6). The child protective services worker shall conduct interviews with collaterals who have pertinent information relevant to the investigation and the safety of the child.

> (22 VAC 40-705-10). "Collateral" means person whose personal or professional knowledge may help confirm or rebut the allegations of child abuse and/or neglect or whose involvement may help ensure the safety of the child.

The CPS worker shall contact any collaterals perceived to have pertinent information. The CPS worker may involve collaterals to help ensure the safety of the child. Contact with the child's other caretakers, such as babysitters or day care providers, is encouraged. The CPS worker may make collateral contacts without the family's consent in order to complete an investigation, but consent and collaboration with the family is encouraged.

The CPS worker shall interview non-victim children as collaterals if it is determined that they may have information which would help in determining the finding in the complaint. Such contact should be made with prior consent of the child's parent,

guardian or agency holding custody. If the situation warrants contact with the child prior to such consent being obtained, the parent, guardian, or agency holding custody should be informed as soon as possible after the interview takes place.

4.8.8 Other contacts may be required

The CPS worker may be required to contact other professionals depending on the type of CPS report. They include:

- Notify the local Commonwealth Attorney if a criminal act is alleged.
- Notify the medical examiner and the regional CPS program consultant if there is a child fatality.
- Notify local law enforcement if there is an alleged criminal act and a joint response is needed.

4.8.9 Document any mandated contacts not made

When any mandated contact or observation is not made, the worker shall document why the specific contact or observation did not occur in the automated data system.

4.8.10 Obtain information to complete the investigation

In developing the case record and the investigative narrative, the CPS worker must address and document in the automated data system these issues. Each investigation may have circumstances warranting more or less details and information.

4.8.10.1 First meaningful contact

The CPS worker shall document the contacts required by regulation in the automated data system. It is equally important that the worker document reasons why any mandated contacts or observations were not made or completed. For example, if three phone messages were left or two home visits made with no one answering the door, those attempts should be documented in the automated data system.

The first meaningful contact in the investigation provides pertinent information relevant to the investigation and the safety of the child and is usually a face-to-face interview with the victim. There could be circumstances in an investigation that the first meaningful contact is with the alleged abuser or collateral. A first meaningful contact could be by telephone.

The first meaningful contact must be documented as such in the automated data system. The CPS worker should confer with a supervisor if there is any doubt about which contact constitutes the first meaningful contact.

4.8.10.2 Incident information

- Gather and document information about the alleged abuse or neglect incident, including the manner of infliction. If applicable, include the precipitating event (what was going on just prior to the occurrence of the abuse or neglect). If applicable, include a description of the environment where the alleged abuse occurred.

- Describe the observable injury or condition of the child (or children) that suggests abuse or neglect has occurred or is likely to occur. Direct observation of the child is always necessary.

- Describe the frequency of the alleged abuse or neglect.

- Describe the medical and psychological treatment given as the result of the alleged abuse or neglect. Any written reports should be included in the case record and documented in the automated data system.

4.8.10.3 Child information

- Demographic information (date of birth, sex, grade in school, etc.).

- Child's developmental level.

- Child's description of the incident including but not limited to:

    - Child's statements about what happened. Include direct quotes of the child if appropriate.

    - Child's statements about the impact of the incident on him.

- Results of any tests or evaluation of the child's injury, behavior, or other characteristics.

- Prior history of abuse or neglect involving the child. The history of any prior abuse or neglect can be provided by any source.

4.8.10.4 Caretaker information

- Demographic information (date of birth, sex, grade in school, etc.).

- Caretaker's developmental level.

- Caretaker's description of the incident including but not limited to:

    - Statements about what happened. Include direct quotes of the child if appropriate.

- Caretaker acknowledgement of responsibility.
- Caretaker's cooperation with the CPS Investigation.
- Is the caretaker taking action to protect the child? If so, describe what action the caretaker is taking.

- Describe the observable or verifiable characteristics and behaviors of the caretaker impacting on the situation (both positive and negative). If drugs or alcohol are having an impact on the situation, this information should be documented in the automated data system. If available, include in the record any results of testing or evaluation.
- Caretaker's history of prior abuse or neglect as either victim or abuser.
- Caretaker's demonstration of a desire or willingness to change or to seek help if appropriate.
- Describe observations of the interaction between the caretaker (even when the caretaker is not a family member, if possible) and the child.

4.8.10.5 Family information

- Describe the family composition.
- Describe observable or verifiable characteristics and behaviors of the family that may impact child safety or risk of abuse or neglect.

4.8.10.6 Other information

- Observable or verifiable characteristics and behaviors of others who have access to the child and the nature of those relationships that may impact child safety or risk of abuse or neglect.
- Factors in the home environment that may impact child safety or risk of abuse or neglect (e.g., eviction, financial circumstances, domestic violence, support systems, etc.).
- Factors outside of the home environment that may impact child safety or risk of abuse or neglect (e.g., school, day care, other service agency contact, etc.).
- Court actions that may impact child safety or risk of abuse or neglect.
- Supports for or obstacles and barriers to services that are needed to ensure the protection of the child or other children.

4.8.11 Dispositional assessment

> (22 VAC 40-705-110 C). In investigations the child protective services worker shall make a dispositional assessment after collecting and synthesizing information about the alleged abuse or neglect.

After collecting evidence and before expiration of the time frames for completing the investigation, the investigating service worker shall determine the disposition. The Virginia Administrative Code provides the definition of disposition.

> (22 VAC 40-705-10). "Disposition" means the determination of whether or not child abuse and/or neglect has occurred.

4.8.11.1 Multiple dispositions and types of abuse or neglect

The Code of Virginia § 63.2-1505 B5 requires that the CPS worker make a founded or unfounded disposition for each allegation in the investigation. For example, an investigation may show sufficient evidence that a child was physically abused and mentally abused. The CPS worker must make a disposition for each category of abuse or neglect. Each separate disposition of abuse or neglect must be supported by a preponderance of the evidence on its own accord.

It is possible that a category of abuse or neglect may have multiple types. For example, the evidence establishes that the child sustained a spiral fracture and internal injuries as a result of the caretaker's actions. The LDSS may render a founded disposition of physical abuse with the type of "bone fracture" and a founded disposition of physical abuse with the type of "internal injury."

4.8.11.2 "Other than accidental means"

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

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

restraining this child with a rope was intended and could have caused more serious harm. The result of the caretaker's actions was not unforeseen or unexpected. Therefore, the injury was not accidental.

In the alternative, a black eye to the child's face while playing catch with the caretaker would be considered accidental. The fact that the ball bounced off the child's mitt and struck the child's eye was not intended. In the first example, the caretaker intended to discipline his child by restraining with a rope for 20 minutes. The intended act of restraining the child caused the injury to the child. In the second example, the caretaker did not intend for the ball to bounce off the child's mitt and hit the child's face. The action causing the black eye was accidental.

4.8.11.3 Incapacitated caretaker

Physical neglect includes when the caretaker is incapacitated to the extent that the caretaker is prevented or severely limited in performing child caring tasks. Incapacitation may include physical incapacitation or mental incapacitation. Mental or physical incapacitation, in and of itself, is not sufficient for a founded disposition. Incapacitation may include mental illness when the mental illness impairs the caretaker's ability to provide for the child's basic needs to the extent that the child's safety or health is jeopardized. Incapacitation may occur as a result of the caretaker's use of controlled substances to the extent that the caretaker is unable to perform child caring duties.

4.8.11.4 Unfounded disposition

The definition of an unfounded disposition as defined in the Virginia Administrative Code is:

> (22 VAC 40-705-10). "Unfounded" means that a review of the facts does not show by a preponderance of the evidence that child abuse or neglect occurred.

However, an unfounded disposition may not mean that abuse or neglect did not occur, but rather that the evidence obtained during the investigation did not reach the preponderance level.

4.8.11.4.1 Risk assessment for unfounded investigation

The CPS worker *must* complete the *Family Risk Assessment Tool* for an unfounded investigation *as risk factors may indicate whether a family is more or less likely to have an incident without intervention by the local agency. Please refer to* Section 4.7.5 *for guidance in completing the Family Risk Assessment Tool and* Section 4.7.5.1 *for guidance in case opening decisions.*

4.8.11.4.2 Notifications in unfounded investigations

- **Written notification to alleged abuser or neglector**. The alleged abuser or neglector shall be notified in writing that the complaint was determined to be unfounded. A copy of the notification shall be filed in the record and documented in the automated data system. The notification shall include the length of time the CPS report will be retained in the automated data system; the individual's right to request the record be retained for an additional period; and the right to access information about himself in the investigative record.

  Although verbal notification of an unfounded investigation is not required by regulation, CPS workers are encouraged to discuss the outcome of the investigation as well as any services the family may need or request.

> (22 VAC 40-705-140 B1). When the disposition is unfounded, the child protective services worker shall inform the individual against whom allegations of abuse and/or neglect were made of this finding. This notification shall be in writing with a copy to be maintained in the case record. The individual against whom allegations of abuse and/or neglect were made shall be informed that he may have access to the case record and that the case record shall be retained by the local department for one year unless requested in writing by such individual that the local department retain the record for up to an additional two years.

- **Inform alleged abuser or neglector of legal recourse if complaint Is malicious.**

> (22 VAC 40-705-140 B1b). The local worker shall notify the individual against whom allegations of abuse and/or neglect were made of the procedures set forth in § 63.2-1514 of the Code of Virginia.

- **Upon request, advise alleged abuser if complainant is anonymous**

> (22 VAC 40-705-40 E). Upon request, the local department shall advise the person who was the subject of the complaint if the complaint or report was made anonymously.

In all unfounded complaints, the worker shall inform the alleged abuser or neglector that he may petition the court to obtain the identity of the complainant if the alleged abuser believes the complaint was made in bad faith or maliciously.

The CPS worker may provide the alleged abuser or neglector with a copy of the Code of Virginia § 63.2-1514 pertaining to reports or complaints made in bad faith or maliciously. Upon request, the LDSS shall advise the person who was the subject of an unfounded investigation if the complaint or report was made anonymously, as required by the Code of Virginia § 63.2-1514. The CPS worker may also refer the person to seek legal advice or to the court if they have further questions.

- **Alleged abuser or neglector may request retention of the record**.

> (22 VAC 40-705-130 A6). The individual against whom unfounded allegations of abuse and/or neglect were made may request in writing that the local department retain the record for an additional period of up to two years.

- **Record shall be purged upon court order**.

> (22 VAC 40-705-130 A7). The individual against whom allegations of abuse and/or neglect were made may request in writing that both the local department and the department shall immediately purge the record after a court rules that the report was made in bad faith or with malicious intent pursuant to § 63.2-1514 of the Code of Virginia.

- **Notify alleged abuser or neglector in unfounded investigation involving the death of a child**.

> (22 VAC 40-705-140 B1c). When an unfounded investigation involves a child death, the child protective services worker shall inform the individual against whom allegations of abuse and/or neglect were made that the case record will be retained for the longer of 12 months or until the State Child Fatality Review Team has completed its review of the case pursuant to § 32.1-283.1 D of the Code of Virginia.

- **Notify victim child's non-custodial parent or guardian**.

> (22 VAC 40-705-140 C1). When the disposition is unfounded, the child protective services worker shall inform the parents or guardian of the subject child in writing, when they are not the individuals against whom allegations of child abuse and/or neglect were made, that the complaint involving their child was determined to be unfounded, and the length of time the child's name and

> information about the case will be maintained. The child protective services worker shall file a copy in the case record.

Reasonable efforts must be made to notify the non-custodial parent of the alleged victim child when that parent is not the subject of a report of child abuse or neglect. Not only does the parent have a right to know, he or she may be a resource to the child. However, if there is reason to believe that contact would be detrimental to the child that should be taken into consideration. If notification does not occur for this or any reason, that reason should be documented in the automated data system. For siblings or other children residing in the home who are not identified as alleged victims, reasonable efforts to notify the non-custodial parent is at the discretion of the LDSS. CPS workers should consider the risk of future maltreatment to these children and the potential protective benefits of notification when making this decision.

- **Notify complainant of unfounded disposition**.

> (22 VAC 40-705-140 D1). When an unfounded disposition is made, the child protective services worker shall notify the complainant, when known, in writing that the complaint was investigated and determined to be unfounded. The worker shall file a copy in the case record.

4.8.11.5 Founded disposition

The definition of a founded disposition as defined in the Virginia Administrative Code is:

> (22 VAC 40-705-10). "Founded" means that a review of the facts shows by a preponderance of the evidence that child abuse and/or neglect has occurred. A determination that a case is founded shall be based primarily on first source evidence; in no instance shall a determination that a case is founded be based solely on indirect evidence or an anonymous complaint.

4.8.11.6 Preponderance of the evidence

The Virginia Administrative Code defines a preponderance of the evidence as:

> (22 VAC 40-705-10). "Preponderance of evidence" means the evidence as a whole shows that the facts are more probable and credible than not. It is evidence which is of greater weight or more convincing than the evidence offered in opposition.

As the standard of proof in making a founded disposition of abuse or neglect, a preponderance of the evidence means that the evidence offered in support of the allegation is of greater weight than the evidence offered in opposition. The

evidence gathered should be evaluated by its credibility, knowledge offered and information provided.

4.8.11.7 First source evidence

First source evidence and indirect evidence are defined in the Virginia Administrative Code:

> (22 VAC 40-705-10). "First source" means any direct evidence establishing or helping to establish the existence or nonexistence of a fact. Indirect evidence and anonymous complaints do not constitute first source evidence.
>
> "Indirect Evidence" means any statement made outside the presence of the child protective services worker and relayed to the child protective services worker as proof of the contents of the statement.

In no instance can a founded disposition be based solely on indirect evidence or an anonymous complaint.

- **First source or direct evidence**. First source or direct evidence means evidence that proves a fact, without an inference or presumption, and which in itself, if true, conclusively establishes that fact. First source evidence includes the parties and witnesses to the alleged abuse or neglect. First source evidence also includes: witness depositions; police reports; photographs; medical, psychiatric and psychological reports; and any electronic recordings of interviews.

  Direct evidence may include witnesses or documents. For example, first source evidence would include a witness who actually saw the alleged act or heard the words spoken. First source evidence would also include the examining physician's report establishing that the child sustained a spiral fracture.

- **Indirect evidence**. Indirect evidence, also known as circumstantial evidence, is evidence based on inference and not on personal knowledge or observation.[6] Indirect evidence relies upon inferences and presumptions to prove an issue in question and may require proving a chain of circumstances pointing to the existence or non-existence of certain facts.

  There is no clear distinction between the reliability and credibility of first source evidence and indirect evidence. It remains incumbent upon the LDSS to weigh the credibility of all the evidence when determining a

[6] Black's Law Dictionary 636, (9th ed. 2009).

disposition. Indirect evidence may be used in support of a founded disposition; however, indirect evidence cannot be the sole basis for the disposition.

4.8.11.8 Factors to determine if medical neglect has occurred

It is the parent's responsibility to determine and obtain appropriate medical, mental and dental care for a child. What constitutes adequate medical treatment for a child cannot be determined in a vacuum, but rather, each case must be decided on its own particular facts.

The focus of the CPS response is whether the caretaker failed to provide medical treatment and whether the child was harmed or placed at risk of harm as a result of the failure. Cultural and religious child-rearing practices and beliefs that differ from general community standards should not be considered a basis for medical neglect, unless the practices present a specific danger to the physical or emotional safety of the child.

4.8.11.8.1 Treatment or care must be necessary

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

The challenging issue is determining when medical care is necessary for the child's health. Obviously, life-saving medical treatment is necessary and falls within the definition. However, when parents or caretakers refuse medical care that is important to their child's well being but is not essential to life, the issue becomes more complicated in determining whether the medical care is necessary.

4.8.11.8.2 Assess degree of harm (real or threatened) to the child

When assessing whether the medical, mental, or dental treatment is necessary for the child's health, the LDSS should consider the degree of harm the child suffered as a result of the lack of care. If the child has yet to suffer harm, then the LDSS should assess the likelihood that the child will suffer harm. The greater the harm, the more necessary the treatment.

In addition to harm, the LDSS should consider the type of medical, mental, or dental condition involved and whether the condition is stable or progressive. Whether the condition is stable or progressive may be an issue in determining the severity of the condition and the necessity of treatment. If

the condition of the child is stable, then the LDSS may consider deferring to the caretaker's authority. If the condition is progressive and left untreated, then the LDSS may give lesser deference to the caretaker's authority.

4.8.11.8.3 Parent refuses treatment for life-threatening condition

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

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

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

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

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

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

"Life-threatening condition" means a condition that if left untreated more likely than not will result in death and for which the recommended medical treatments

> carry a probable chance of impairing the health of the individual or a risk of terminating the life of the individual.

4.8.11.8.4 Assess caretaker's rationale

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

4.8.11.8.5 Assess financial capabilities and poverty

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

4.8.11.8.6 Failure to thrive must be diagnosed by a physician

The CPS worker must document that the diagnosis of failure to thrive was made by a physician and the diagnosis was nonorganic failure to thrive.

4.8.11.9 Child under alternative treatment

> (22 VAC 40-705-30 C1). A child who, in good faith, is under treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination pursuant to § 63.2-100 of the Code of Virginia, shall not for that reason alone be considered a neglected child.

The Code of Virginia provides that no child shall be considered an abused or neglected child only for the reason that the child is under treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination. The religious exemption to a

founded disposition of child abuse or neglect mirrors the statute providing a religious defense to criminal child abuse and neglect.[7] This exemption means that a founded disposition cannot be based only upon the religious practices of the parents or caretakers. A founded disposition can be rendered for other reasons. For example, if the parent caused the injury in the first place, the religious exemption would not apply. The religious exemption to a founded disposition of abuse or neglect is designed to protect a family's right to freedom of religion. The religious exemption statute is not to provide a shield for a person to abuse or neglect a child.[8]

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

4.8.11.10 Medical neglect of infants with life-threatening conditions

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

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

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

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

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

4.8.11.10.1 Withholding medically indicated treatment when treatment is futile

(22 VAC 40-705-30 C2). For the purposes of this regulation, "withholding of medically indicated treatment" does not include the failure to provide treatment (other than appropriate nutrition, hydration, or medication) to an infant when in the treating physician's or physicians' reasonable medical judgment:

a. The infant is chronically and irreversibly comatose;

b. The infant has a terminal condition and the provision of such treatment would:

(1) Merely prolong dying;

(2) Not be effective in ameliorating or correcting all of the infant's life-threatening conditions; or

(3) Otherwise be futile in terms of the survival of the infant; or

(4) The infant has a terminal condition and the provision of such treatment would be virtually futile in terms of the survival of the infant and the treatment itself under such circumstances would be inhumane.

4.8.11.10.2 Definitions of chronically and irreversibly comatose and terminal condition

(22 VAC 40-705-10). "Chronically and irreversibly comatose" means a condition caused by injury, disease or illness in which a patient has suffered a loss of consciousness with no behavioral evidence of self-awareness or awareness of surroundings in a learned manner other than reflexive activity of muscles and nerves for low-level conditioned response and from which to a reasonable degree of medical probability there can be no recovery.

(22 VAC 40-705-10). "Terminal condition" means a condition caused by injury, disease or illness from which to a reasonable degree of medical probability a patient cannot recover and (i) the patient's death is imminent or (ii) the patient is chronically and irreversibly comatose.

4.8.11.11 Founded disposition cannot be based solely on anonymous complaint

A founded disposition cannot be based solely on an anonymous complaint. An allegation of abuse or neglect, in and of itself, cannot prove that the alleged act or omission did or did not occur. Because a person alleges that an act occurred

does not mean that the act in fact did occur. The allegation must be proved or disproved by corroborating evidence.

4.8.11.12 Alleged abuser may consult with LDSS prior to a founded disposition

> (22 VAC 40-705-120 D). The subject of the report or complaint may consult with the local department to hear and refute evidence collected during the investigation. Whenever a criminal charge is also filed against the alleged abuser for the same conduct involving the same victim child as investigated by the local department, sharing the evidence prior to the court hearing is prohibited.

The alleged abuser may be informed at any time during the investigation that the facts are leading the worker toward making a founded disposition.

If the alleged abuser/neglector wants to present additional evidence or refute evidence, the LDSS may afford this opportunity and consider such additional information prior to rendering the disposition. The investigation may be extended from 45 days to 60 days for this process to be completed.

The request for a consultation prior to disposition does not apply if there are pending criminal charges involving the same victim child.

4.8.11.13 Polygraph examinations are not considered reliable evidence

Polygraph examinations are not admissible as evidence in CPS administrative hearings and cannot be considered as evidence when an LDSS is making a disposition. Since the Virginia Supreme Court has repeatedly ruled that polygraph examinations are scientifically unreliable, an LDSS cannot allow polygraph examinations to be entered in as evidence in support of a founded disposition.[9]

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[9] In *Robinson v. Commonwealth*, 231 Va. 142, 341 S.E.2d 159 (1986), the Virginia Supreme Court stated, "[I]n a long line of cases, spanning almost thirty years, we have made clear that polygraph examinations are so thoroughly unreliable as to be of no proper evidentiary use whether they favor the accused, implicate the accused, or are agreed upon to by both parties." Virginia courts have not specifically addressed the use of polygraphs in administrative hearings. However, in light of the courts' strong opposition to using results of polygraph testing in evidence, we see no principled distinction between the use of a polygraph in court and use in an administrative hearing. In *Dept. of Public Safety v. Scruggs*, 79 Md. App. 312, 556 A.2d 736 (1989), the court acknowledged that administrative agencies are not bound by the strict rules of evidence, but stated that such evidence must be competent. The court found polygraph evidence so unreliable as to deem it "incompetent" evidence. The Supreme Court relied on *Robinson* in 2004 in *Elliott v. Commonwealth*, 267 Va. 396, 593 S.E.2d 270 (2004).

4.8.11.14 Founded disposition and identity of abuser is unknown

It is possible that an investigation reveals a preponderance of evidence establishing that the child was physically abused or physically neglected, but fails to establish, by a preponderance of that evidence, the caretaker responsible for the abuse or neglect. If, after diligent efforts to identify the abuser, the identity of the abuser remains unknown, the LDSS may enter the abuser's name as "unknown" into the automated data system.

For example, the evidence establishes that the infant was shaken and sustained severe injuries. The only persons with the opportunity to have caused the injuries were the parents of the infant and the babysitter who provided care for the infant on the night the injuries occurred. However, the evidence is conflicting concerning who actually caused the injuries. In such a situation, the LDSS may render a founded disposition of physical abuse with the identity of the abuser unknown.

- **Abuser identified after disposition**. If new information is received subsequent to a disposition of Founded with Unknown Abuser, this information is to be treated as a new referral and requires a new investigation. If the original information is still pertinent and relevant and there is sufficient reason not to re-interview all the required contacts, such as potential trauma to the child, the information from original interviews may be incorporated into the new investigation. If this additional information allows for a founded disposition with a known abuser, it does not replace the original finding.

4.8.12 Determine level of founded disposition

A founded disposition must be categorized into one of three levels. Categorization is dependent on the nature of the act and the seriousness of the harm or threatened harm to the child as a result of maltreatment. In all founded cases, there may be circumstances influencing the severity of the abusive or neglectful incident. The circumstances may increase or decrease the severity of harm or threatened harm.

The level for a founded disposition must be supported by a preponderance of the evidence. The evidence supporting the level must be documented in the record. The facts supporting the level will relate to the type and pattern of abuse/neglect, the vulnerability of the child, the effect or potential effect of the abuse/neglect, and the action or inaction of the caretaker.

4.8.12.1 Level 1

> (22 VAC 40-700-20 1). Level 1. This level includes those injuries/conditions, real or threatened, that result in or were likely to have resulted in serious harm to a child.

Injuries or conditions that resulted in or were likely to have resulted in serious harm include but are not limited to:

- For physical abuse, the situation requires medical attention in order to be remediated; the injury may be to the head, face, genitals, or is internal and located near a vital organ; injuries located in more than one place; the injuries were caused by the use of an instrument such as a tool or weapon; an inappropriate drug was administered or a drug was given in an inappropriate dosage; child exposed to the production or sale of methamphetamine or other drug and is not able to self-protect.

- For neglect situations, the condition would be one where the child's minimal needs are rarely met for food, clothing, shelter, supervision, or medical care; the child is frequently unsupervised or unprotected; the child is left by the caretaker with no plan for the child's care or no information about the caretaker's whereabouts or time for return; or a young child is left alone for any period of time.

- For mental abuse or neglect, the child has engaged in self-destructive behavior, or has required psychiatric hospitalization, or required treatment for severe dysfunction or for presenting a danger to self or others, or for problems related to the caretaker behavior.

- For sexual abuse, the situation would be one where there was genital contact, or force or threat was used, or the abuse had taken place over a period of time and there were multiple incidents.

- For medical neglect, caretaker failed to provide medical care in a life threatening situation or a situation that could reasonably be expected to result in a chronic debilitating condition.

- For non-organic failure to thrive, the syndrome is considered to be a form of physical or emotional maltreatment, so refer to bullets 2 and 3 above.

4.8.12.2 Level 2

> (22 VAC 40-700-20 2). Level 2. This level includes those injuries/conditions, real or threatened, that result in or were likely to have resulted in moderate harm to a child.

Injuries or conditions that resulted in or were likely to have resulted in moderate harm include but are not limited to:

- For physical abuse, the injury necessitates some form of minor medical attention; injury on torso, arms, or hidden place (such as arm pits); use of tool that is associated with discipline such as a switch or paddle,

exposure to the production or sale of methamphetamine or other drugs and the child may not be able to self protect.

- For neglect situations, the condition would be one where the child's minimal needs are sporadically met for food, clothing, shelter, supervision, or medical care; or a pattern or one-time incident related to lack of supervision caused or could have caused moderate harm.

- For mental abuse or neglect, the situation would be one where the child's emotional needs are rarely met; the child's behavior is problematic at home or school;

- For sexual abuse, minimal or no physical touching but exposure to masturbation, exhibitionism, etc. Caretaker makes repeated sexually provocative comments to the child; child is exposed to pornographic materials.

- For medical neglect, the situation is one in which a doctor has prescribed care to eliminate pain or remedy a condition but the caretaker has not followed through with appointments or recommendations; the child's condition is not acute or life threatening but could be detrimental to the child's mental or physical health.

- For non-organic failure to thrive, the syndrome is considered to be a form of physical or emotional maltreatment, so refer to bullets 2 and 3 above.

4.8.12.3 Level 3

> (22 VAC 40-700-20 3). Level 3. This level includes those injuries/conditions, real or threatened, that result in minimal harm to a child.

Injuries or conditions that resulted in or were likely to have resulted in minimal harm include but are not limited to:

- For physical abuse, the situation requires no medical attention for injury, including minimal exposure to the production or sale of methamphetamine or other drugs.

- In physical neglect, child's minimal needs inconsistently met for food, clothing, shelter, supervision, or medical care; supervision marginal, poses threat of danger to child.

- For mental abuse or neglect, the situation would be one where the child's emotional needs are met sporadically with evidence of some negative impact on the child's behavior.

- For sexual abuse, there was no or minimal physical touching or exposure to sexual acts such as masturbation, exhibitionism, etc. Caretaker's actions or behavior, such as making sexually suggestive comments to the child, causes or creates a threat of minimal harm to the child.

- For medical neglect, the situation may be one in which the child's life is not in danger, the child is not experiencing discomfort at this time, but the medical authority reports medical treatment is needed to avoid illness or developmental delay.

- For non-organic failure to thrive, the syndrome is considered to be a form of physical or emotional maltreatment, refer to bullets 2 and 3 above.

4.8.13 Determine risk level in founded investigations

> (22 VAC 40-705-110 B). In all founded cases and in completed family assessments, the child protective services worker shall make a risk assessment to determine whether or not the child is in jeopardy of future abuse and/or neglect and whether or not intervention is necessary to protect the child.

If the LDSS makes a founded disposition of abuse or neglect, then the LDSS shall complete the third type of assessment, the risk assessment. *Please refer to* Section 4.7.5 *for guidance in completing the Family Risk Assessment Tool and* Section 4.7.5.1 *for guidance in case opening decisions.*

4.8.14 Risk level determines need to convene family partnership meeting

A family partnership meeting should be scheduled by the LDSS when the worker assesses a child to be at "very high" or "high" risk of abuse and/or neglect and the child is at risk of out of home placement in those families who will be or are receiving services. This meeting is scheduled to develop the plan and services to prevent the out of home placement and identifies the circumstances under which a removal might be considered. The meeting should convene **within 30 days** of initiating services and prior to the development of the ongoing service plan. The family partnership meeting must be documented in the automated data system. For guidance on conducting the family partnership meeting, refer to the Family Engagement manual, available on the websites below:

DSS internal website

DSS public website

4.8.15 Cannot reopen a closed investigation

There is no basis in the Code of Virginia or the Virginia Administrative Code for "reopening" a closed investigation. When new or additional information is received

after a complaint has been determined to be Unfounded, the new/additional information may be sufficient to meet the validity criteria for a new CPS report. If the new information adds nothing more to the original complaint, the report should be screened out.

4.8.16 Notifications in founded investigations

4.8.16.1 Notify abuser or neglector in writing

The written notification to the abuser or neglector of the founded disposition(s) must be in a letter and a copy must be included in the case record. The letter must include:

- A clear statement that the individual is the abuser and/or neglector.
- The category of abuse and/or neglect.
- The disposition, level, and retention time, including statement about effect of multiple complaints on retention.
- The name of the victim child or children.
- A statement informing the abuser of his or her right to appeal the finding and to have access to the case record.
- A statement informing the abuser that pursuant to § 63.2-1505 of the Code of Virginia, if the abuser is a teacher in a public school division in Virginia, the local school board shall be notified of the founded disposition.

LDSS are encouraged to send the disposition letter by certified mail as further documentation of the notification to the abuser or neglector.

4.8.16.1.1 Additional notification to alleged abuser in certain founded sexual abuse investigations

The Code of Virginia § 63.2-1514 A requires that all records related to founded cases of child sexual abuse involving injuries or conditions, real or threatened, that result in or were likely to have resulted in serious harm to a child shall be maintained by the LDSS for a period of 25 years from the date of the complaint. All investigation records founded on or after July 1, 2010 for sexual abuse investigations level 1 shall be maintained by the LDSS 25 years from the date of the complaint. This retention timeframe will not be reflected in the Central Registry past the purge dates set out in 22 VAC 40-700-30.

For all sexual abuse investigations founded level 1 on or after July 1, 2010, the written notification shall include a statement informing the alleged abuser that the investigation record shall be maintained by the LDSS for 25 years past the date of the complaint pursuant to § 63.2-1514 A of the Code of Virginia; however, this retention time will not be reflected in the Central Registry past the purge date of 18 years as set out in 22 VAC 40-700-30.

4.8.16.2 Inform abuser or neglector of appeal rights

The abuser or neglector must be informed of his right to appeal the founded disposition. This must be done verbally and in writing as soon as the disposition is reached. In addition, the abuser or neglector must be given a brochure, "Child Protective Services Appeals and Fair Hearings" that outlines the administrative appeal process. The LDSS must document in the automated data system that the abuser or neglector was given the appeal brochure and was informed verbally of his or her appeal rights.

4.8.16.3 Notify abuser or neglector verbally

The verbal notification to the abuser or neglector of the founded disposition(s) should include the disposition, level, and retention time, including effect of multiple complaints on retention and inform the abuser of his or her right to appeal to finding and to have access to the case record. The worker must document in the automated data system, the date the verbal notification took place. If the verbal notification did not occur, the CPS worker should document the reasons in the automated data system.

4.8.16.4 Foster parent is abuser or neglector of the victim child in founded complaint

> (22 VAC 40-705-140 B4). When the abuser and/or neglector in a founded complaint is a foster parent of the victim child, the local department shall place a copy of this notification letter in the child's foster care record and in the foster home provider record.

4.8.16.5 Notify all parties if identity of abuser or neglector is unknown

If the LDSS renders a founded disposition with the abuser unknown, the LDSS must notify all parties, including the parents or guardian of the child, the alleged abuser or neglector, and the complainant. All parties must be informed that the investigation resulted in a finding that the child was abused or neglected, but the evidence did not establish the identity of the perpetrator.

The alleged abuser or neglector should be notified that a finding of abuse or neglect was not made against that person. Because the abuser or neglector is

unknown, no party has the right to an administrative appeal of the founded disposition.

The complainant should be notified that necessary action was taken.

4.8.16.6 Notify all parties if abuser or neglector is deceased

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

If the LDSS renders a founded disposition and the named abuser or neglector is deceased, the LDSS must notify all parties, including the deceased abuser or neglector's estate. The notification letter must state that the identity of the alleged abuser or neglector will be referred to as "deceased" in the automated data system. Because the abuser or neglector is deceased, no party has the right to an administrative appeal of the founded disposition.

The complainant should be notified that necessary actions were taken.

4.8.16.7 Notify victim child's non-custodial parent or guardian

> (22 VAC 40-705-140 C2). When the disposition is founded, the child protective services worker shall inform the parents or guardian of the child in writing, when they are not the abuser and/or neglector, that the complaint involving their child was determined to be founded and the length of time the child's name and information about the case will be retained in the Central Registry. The child protective services worker shall file a copy in the case record.

Reasonable efforts must be made to notify the non-custodial parent of the alleged victim child when that parent is not the subject of a report of child abuse or neglect. Not only does the parent have a right to know, he or she may be a resource to the child. However, if there is reason to believe that contact would be detrimental to the child, that should also be taken into consideration. If notification does not occur for this or any reason, that reason should be documented in the automated data system. For siblings or other children residing in the home who are not identified as alleged victims, reasonable efforts to notify the non-custodial parent is at the discretion of the LDSS. CPS workers should consider the risk of future maltreatment to these children and the potential protective benefits of notification when making this decision.

For all sexual abuse investigations founded level 1 on or after July 1, 2010, the notification to the parent of the alleged victim child shall include a statement that the investigation record shall be maintained by the LDSS for 25 years past

the date of the complaint pursuant to § 63.2-1514 A of the Code of Virginia; however, this retention time will not be reflected in the Central Registry past the purge date of 18 years as set out in 22 VAC 40-700-30.

4.8.16.8 Notify complainant

> (22 VAC 40-705-140 D2). When a founded disposition is made, the child protective services worker shall notify the complainant, when known, in writing that the complaint was investigated and necessary action was taken. The local worker shall file a copy in the case record.

4.8.16.9 Notify military personnel (Family Advocacy Program)

The Code of Virginia § 63.2-1503 N establishes authority for the LDSS to share CPS information with family advocacy representatives of the United States Armed Forces.

> (22 VAC 40-705-140 E). Family Advocacy Program. When a founded disposition is made, the child protective services worker shall notify the Family Advocacy Program representative in writing as set forth in 22 VAC 40-720-20.

In founded complaints where a need for protective services is identified in which the abuser or neglector is an active duty member of the United States Armed Forces, or the spouse of a member residing in the member's household, information regarding the disposition, type of abuse or neglect, and the identity of the abuser or neglector shall be reported to the appropriate Family Advocacy Program representative at the time of the disposition. See Section 9, Confidentiality, of this manual for guidance on other information disclosure to Family Advocacy.

- Written notification to Family Advocacy shall be made **within 30 days** of founded disposition.

  The Family Advocacy Program representative shall also be notified in writing **within 30 days** after all administrative appeal rights of the abuser or neglector have been exhausted or forfeited.

- Written notification to abuser or neglector.

  The abuser or neglector shall be advised that this information is being provided to the Family Advocacy Program and shall be given a copy of the written notification sent to the Family Advocacy Program.

4.8.16.10 Referral to early intervention programs for children under age three in founded investigations

The CPS worker is required to refer a child under the age of three in a founded investigation for early intervention services. All localities are served by an Infant & Toddler Connection of Virginia program. This referral is required by the Child Abuse Prevention and Treatment Act (CAPTA). In Virginia, the eligible population is infants and toddlers from birth to age three who are developmentally delayed, who have atypical development, or who have a diagnosed physical or mental condition that has a high probability of resulting in delay.

LDSS are encouraged to meet with the local Infant and Toddler program to learn about any referral issues that should be explained to the parent. LDSS are also encouraged to develop procedures with the Infant & Toddler Connection of Virginia program to make referrals of children under age three in founded investigations who may be eligible for these services. Recommended elements of these procedures could include:

- **Within five (5) working days** of completing the investigation the LDSS will send a referral to the local Part C Early Intervention program using the local referral form.

- The LDSS will send a copy of the referral to the family with the notice of disposition. The parent shall also be informed verbally of the referral and have an opportunity to discuss the referral process.

- The LDSS will request the family to sign a release form allowing the exchange of information between the Infant-Toddler Connection Program and the LDSS regarding the referral.

More information on the Infant & Toddler programs in Virginia can be found on the Infant & Toddler Connection of Virginia website and in the joint Memorandum of Understanding issued by the Commissioners of the Department of Social Services and Department of Behavioral Health and Developmental Services dated May 2010 and included in Appendix I.

4.8.16.11 Notify parents of a minor who is an abuser

When a child under the age of eighteen is the abuser in a founded investigation, the LDSS shall inform the parents and/or legal guardian of the minor of the finding and the abuser's right to appeal the finding. The minor's parents/legal guardians have the authority to initiate an administrative appeal of the founded disposition on behalf of the minor.

4.8.16.12 Notify local school board when abuser is a teacher

Pursuant to § 63.2-1505 of the Code of Virginia, if the abuser is a full-time, part-time, permanent, or temporary teacher in a school division located within the Commonwealth, the LDSS shall notify the local school board of the founded disposition made after July 1, 2008 at the same time the subject is notified of the founded disposition. This includes in home investigations when the teacher is the subject of the founded investigation involving his own children. Any information exchanged for the purposes of this subsection shall not be considered a violation of § 63.2-102, 63.2-104 or 63.2-105.

The LDSS may send a copy of the disposition letter to the subject of the complaint to the local school board to meet this notification requirement.

This notification requirement applies only to teachers who are employed by a local school board at the time of the disposition of the complaint. The notification requirement does not apply to other local school board employees.

4.8.16.13 Notify State Superintendent of Public Instruction when abuser holds a license issued by the Board of Education

Pursuant to § 63.2-1503 P of the Code of Virginia, the LDSS shall notify the Superintendent of Public Instruction when an individual holding a license issued by the Board of Education is the subject of a founded complaint of child abuse or neglect and shall transmit identifying information regarding such individual if the LDSS knows the person holds a license issued by the Board of Education and after all rights to any appeal provided by § 63.2-1526 have been exhausted up to and including appeals to the circuit court. Any information exchanged for the purpose of this subsection shall not be considered a violation of § 63.2-102, 63.2-104, or 63.2-105.

The Board of Education issues licenses to instructional personnel including teachers and other professionals and administrators. Refer to Licensure Regulations for School Personnel in the Virginia Administrative Code.

The Board of Education does not license teacher aides, janitorial staff, and support administrative staff.

This notification requirement applies to all individuals holding a license even if that person is not currently employed by a local school board.

4.8.17 Investigation of medical neglect of disabled infants with life-threatening conditions

After receiving a complaint or report involving the withholding of medical treatment of an infant, the LDSS should initiate contact with the designated person in the hospital. The LDSS should arrange with the local hospital for naming a contact person or liaison. The LDSS may contact the CPS State Hotline because the hospital's contact name is available from the CPS State Hotline and the list is up-dated annually. Upon receipt of the complaint or report, the CPS worker should immediately:

- Verify the child's presence at the hospital by contacting the hospital's liaison.
- Verify the child's status.

4.8.17.1 Contact physician or hospital staff

The LDSS should arrange to meet with the attending physician or the Infant Care Review Panel and conduct a visit to the hospital to verify the child's situation.

4.8.17.2 Determine who is responsible for the child

The CPS worker should make a site visit and determine who is responsible for the child. This will usually be the child's parents, unless the parents have abdicated their authority. Situations when the parents are not responsible include, but are not limited to:

- When parents permanently voluntarily entrust the child to an agency.
- When a third trimester abortion results in a live birth.[10]

4.8.17.3 Seeking Court assistance

When treatment appears necessary and the Court is available to act on a petition, the worker can:

- Petition the Court for custody so that treatment can be provided.

[10] § 18.2-74 of the Code of Virginia provides that in any termination of human pregnancy aided or assisted by a licensed physician subsequent to the second trimester, measures for life support for the product of such abortion or miscarriage must be available and utilized if there is any clearly visible evidence of viability. The physician would be responsible for providing that the life sustaining measures were provided in these instances.

- Petition the Court for a Protective Order specifying that treatment be provided.

When emergency treatment is necessary and the Court is unavailable, the worker should consider taking the child into custody pursuant to The Code of Virginia § 63.2-1517.

4.9 Family assessment and investigation case record

All family assessments or investigations must be documented in the automated data system. The CPS worker will collect information from a variety of sources in conducting a family assessment or investigation.

4.9.1 All family assessments and investigations must be documented in the automated data system

> (22 VAC 40-705-10). "Documentation" means information and materials, written or otherwise, concerning allegations, facts and evidence.

Thorough and detailed documentation of the family assessment or investigation is essential to determine and support the decisions made by the CPS worker and approved by the supervisor. All family assessment and investigation records must contain the information required by law, regulation, and guidance.

4.9.2 Case record

> (22 VAC 40-705-10). "Case Record" means a collection of information maintained by a local department, including written material, letters, documents, tapes, photographs, film or other materials regardless of physical form about a specific child protective services investigation, family or individual.

4.9.3 Family assessment or investigation documentation

> (22 VAC 40-705-10). "Investigative narrative" means the written account of the investigation contained in the child protective services case record.

The family assessment or investigative narrative is a detailed written summary of all the evidence supporting the LDSS's investigation disposition or information supporting the family assessment. All documentation must be entered into the automated data system.

A hard copy file, in addition to the automated data system generated reports, for each family assessment or investigation may be needed to include correspondence, reports from other sources (school, medical, etc.), and other documentation germane to the family assessment or investigation.

4.9.4 Supervisory review

All completed family assessments and investigations must be reviewed and approved in the automated data system by the CPS worker and the CPS worker's supervisor **within five (5) working days**.

4.10 CPS automated data system

CPS reports including screened out reports, investigations, and family assessments, must be maintained in an automated data system.

> (22 VAC 40-705-10). "Child Abuse and Neglect Information System" means the computer system which collects and maintains information regarding incidents of child abuse and neglect involving parents or other caretakers. The computer system is composed of three parts: the statistical information system with non-identifying information; the Central Registry of founded complaints not on appeal; and a data base that can be accessed only by the Department and local departments that contains all non-purged CPS reports.

4.10.1 Central Registry

The Code of Virginia § 63.2-1515 establishes authority for the Central Registry and governs disclosure of information from the central registry.

> (22 VAC 40-705-10). "Central Registry" means a subset of the child abuse and neglect information system, and is the name index with identifying information of individuals named as an abuser and/or neglector in founded child abuse and/or neglect complaints or reports not currently under administrative appeal, maintained by the Department.

4.10.2 CPS database available to LDSS

> (22 VAC 40-705-130 A1). The Department shall retain unfounded complaints and/or reports in the child abuse and neglect information system to provide local departments with information regarding prior investigations.
>
> (22 VAC 40-705-130 A2). This record shall be kept separate from the Central Registry and accessible only to the Department and to local departments.

In addition to CPS reports contained in the Central Registry, the automated data system contains a database of all non-purged CPS reports that can only be accessed by the LDSS. This database contains all pending CPS investigations and family assessments as well as completed family assessments, unfounded investigations, and screened out reports.

4.10.3 Retain record if subsequent complaints arise

(22 VAC 40-705-130 A5). If the individual against whom allegations of abuse and/or neglect were made or if the same child is involved in subsequent complaints and/or reports, the information from all complaints and/or reports shall be maintained until the last purge date has been reached.

4.10.4 Retention period for family assessment

(22 VAC 40-705-130 A4). The record of the family assessment shall be purged three years after the date of the complaint or report if there are no subsequent complaints and/or reports regarding the individual against whom allegations of abuse and/or neglect were made or regarding the same child in those three years.

4.10.5 Retention period for investigation with unfounded disposition

(22 VAC 40-705-130 A). Pursuant to § 63.2-1514 of the Code of Virginia, the local department shall report all unfounded case dispositions to the child abuse and neglect information system when disposition is made.

4.10.5.1 Purge unfounded disposition after one year

(22 VAC 40-705-130 A3). The record of the unfounded case shall be purged one year after the date of the complaint or report if there are no subsequent founded or unfounded complaints and/or reports regarding the individual against whom allegations of abuse and/or neglect were made or regarding the same child in that one year.

4.10.6 Retention period for investigation with founded fisposition

(22 VAC 40-705-130 B). The local department shall report all founded case dispositions to the child abuse and neglect information system for inclusion in the Central Registry pursuant to subdivision 5 of § 63.2-1515 of the Code of Virginia and 22 VAC 40-700-30. Identifying information about the abuser and/or neglector and the victim child or children reported include demographic information, type of abuse or neglect, and date of the complaint. The identifying information shall be retained based on the determined level of severity of the abuse or neglect pursuant to the regulation dealing with retention in the Central Registry, 22 VAC 40-700-30.

Pursuant to 22 VAC 40-700-30, names will be retained in the central registry for:

1. Eighteen years past the date of the complaint for all complaints determined by the investigating agency to be founded, Level 1.

2. Seven years past the date of the complaint for all complaints determined by the investigating agency to be founded, Level 2.

3. Three years past the date of the complaint for all complaints determined by the investigating agency to be founded, Level 3.

If an individual is involved in multiple complaints, the information from all complaints will be maintained until the last deletion date has been reached.

4.10.6.1 LDSS to retain certain sexual abuse case records 25 years

The Code of Virginia § 63.2-1514 A requires that all records related to founded cases of child sexual abuse involving injuries or conditions, real or threatened, that result in or were likely to have resulted in serious harm to a child shall be maintained by the LDSS for a period of 25 years from the date of the complaint. All investigation records founded on or after July 1, 2010 for sexual abuse investigations level 1 shall be maintained by the LDSS 25 years from the date of the complaint. This retention timeframe will not be reflected in the Central Registry past the purge dates set out in 22 VAC 40-700-30.

4.10.7 Retention period for reports involving a child death

The record of a child fatality report, whether screened out, founded, or unfounded, should be maintained until the State Child Fatality Review Team has had an opportunity to review it. The Code of Virginia § 32.1-283.1 D requires the LDSS to maintain these CPS records beyond the usual retention periods for CPS records. Contact the regional consultant if there is any question about retention of a specific record.

4.10.8 CPS statistical information

The automated data system provides non-identifying statistical information about the CPS program.

4.11 CPS Central Registry searches

It is the responsibility of the Department to maintain an automated data system for CPS and to respond to requests for searches of the Central Registry. Many organizations that work with children require a search of the Central Registry as a condition of employment. In addition, the Code of Virginia § 63.2-1515 requires the VDSS to respond to requests to search the Central Registry for employment by the LDSS and local school boards.

4.11.1 Individual whose name is being searched must authorize the Central Registry search

(22 VAC 40-705-170 A). The department will complete a search of the Central Registry upon request by a local department, upon receipt of a notarized signature of the individual whose name is being searched authorizing release of such information or a court order specifying a search of the Central Registry.

4.11.2 Name is found in Central Registry

(22 VAC 40-705-170 B). When the name being searched is found in the Central Registry, the department shall contact the local department responsible for the investigation to verify the information.

4.11.2.1 LDSS cannot verify that client was notified of appeal rights

If the LDSS cannot produce documentation that the client was notified of his appeal rights, the LDSS must review the case file. The LDSS must determine whether to retain or amend the founded disposition or to purge the complaint based on the documentation in the case record. The LDSS may consult the CPS Regional Specialist for assistance.

The LDSS must review the case record and notify the Central Registry Search Unit **within five (5) working days**.

4.11.2.2 Written notification to abuser or neglector of disposition and appeal rights

If the LDSS cannot verify that the client was informed of his appeal rights and the LDSS determines that the founded disposition shall be maintained, the LDSS must inform the client of his right to appeal the founded disposition of abuse or neglect.

4.11.3 Notification of Central Registry search results

The VDSS will return the completed search form to the authorized agent named on the search request. If the individual's name is in the Central Registry, the VDSS will also send a copy of this form to the individual whose name was searched and to the LDSS responsible for the name being entered into the Central Registry.

4.11.3.1 LDSS must release information to abuser or neglector upon request

If the individual contacts the LDSS regarding his name entry into the Central Registry, the LDSS shall provide the individual with the requested information and provide a copy of the appeal procedures to the individual.

4.11.3.2 Abuser or neglector may request appeal

If the individual decides to appeal the founded disposition or dispositions, then the LDSS must respond to the request for a local conference.

4.12 Appendix A: Suggested practices when audio taping an interview with a child

4.12.1 CPS worker's immediate objectives

In order to accomplish the task of audio taping, the worker should always remember to be patient, observant, flexible and a good listener during the interview with a child. In conducting an audio taped interview with a victim child, the following goals may be met:

- Minimize trauma to the child.
- Maximize the amount and quality of the information obtained while minimizing any contamination of that information.
- Maintain the integrity of the investigation process for the agencies involved.

4.12.2 General operating procedure and equipment

The worker, before each interview with the subject child, should ensure the audio taping equipment is in operating order.

- A new tape is to be used for each incident investigated.
- The worker may record more than one interview with the subject child on the tape; however, care needs to be taken to leave sufficient space between each interview.
- If the investigation involves more than one child, each child shall have his own tape. Each tape should be labeled and identified by the child's name, the date of the complaint, complaint number, the worker's name, location of the interview, and show the dates of all interviews included on the tape.
- Whenever possible, the worker should note the location on the tape of information related to identification of the complainant. This can be done by looking at the number on the tape counter on the tape recorder.

4.12.3 Pre-interview information gathering

Prior to conducting the interview, the worker should gain as much information about the child and the alleged incident as possible. The worker should know the child's age, verbal skills, developmental level, and vocabulary. For example, if the allegation is sexual abuse, the worker should know if the child has any prior founded reports of sexual abuse and what are the names the child uses to describe body

parts. Never assume that you know what a child means by the use of a particular word. Always ask if the meaning is not obvious. Make certain that you are using words and concepts which the child understands.

4.12.4 Location of interview

Determine the location of the interview. It is preferable to interview the child in a neutral setting that provides privacy and no inward or outward stimuli or cause for interruption. However, there may be no opportunity when dealing with an emergency situation to have all these elements in place. Should the worker be faced with this, every effort should be made to incorporate as many of the above elements as possible.

4.12.5 Prepare questions

Given the time allowed, the worker should plan the interview and write down some of the questions that he or she wants to ask the child.

4.12.6 Who may be present for the interview

- The worker has the authority to determine who is to be present during the interview.
- If an interview room is equipped with a two-way mirror or a video monitor, the worker may permit a parent, guardian, or therapist to observe the interview. Be sure that support is given to the parent(s) observing the interview.
- If the worker is investigating with a law enforcement officer, a decision should be made prior to conducting the interview who will be the lead interviewer. The person not interviewing may, instead, operate the tape recorder.
- It is preferable if a joint investigation is no being conducted, that only the child and the worker be present at the interview; however, should the child's comfort depend on another person being present in the room during the interview, the worker should impress on the person the importance of not interfering with the interview.
- All persons observing the interview should remain silent. Observers present in the room should be seated out of the visual site of the child. Observers be advised that they may hear information that could illicit a non-verbal reaction and that it is essential they show no reaction at all as it could contaminate the interview.

4.12.7 The interviewing worker needs to be aware of circumstances

- The CPS worker should also be aware of his or her own reactions.
- The CPS worker should always be aware of the child's physical needs and capabilities such as:
  - Attention span.
  - Nutritional requirements.
  - Body functions.

  For example, do not try to conduct the interview with a young child when they would normally nap or when it is time for them to eat.
- It is okay to allow the young child to draw, play with a toy, move about the room, etc. while the interview occurs.
- The CPS worker should always keep in mind that this is a fact finding interview not a therapeutic one, yet that does not mean the investigative interview needs to be a traumatic experience.

4.12.8 Beginning the recording of the interview

- After the recording device has been turned on, the interviewer should state the date, time, location, and names of those present in the room.
- The CPS worker should explain his/her role to the child and the role of anyone else present in the room and state the purpose of the interview.
- The worker should then engage the child in general conversation asking him to state his name and age. The worker may ask the child to talk about his favorite subject in school, a favorite hobby, or how they like to spend their free time. Have him describe a favorite event, i.e., last birthday or special trip. Here is where it is important to be flexible and know the child you are interviewing. For instance, if you are interviewing an older child, they may want to minimize this stage and get straight into the discussion of the allegation.

4.12.9 General interviewing questions and techniques

- If I misunderstand something you say, please tell me. I want to know. I want to get it right.
- If you don't understand something I say, please tell me and I will try again.

- If you feel uncomfortable at any time, please tell me or show me the stop sign (determine what that is to be).
- Even if you think I already know something, please tell me anyway.
- If you are not sure about an answer, please do not guess. Tell me you're not sure before you say it.
- Please remember when you are describing something to me that I was not there when it happened. The more you can tell me about what happened, the more I will understand what happened.
- Please remember that I will not get angry or upset with you.
- Only talk about things that are true and really happened.
- Stress that you, the interviewer, will follow these rules.

4.12.10 Determine the child's capacity for truthfulness

The worker needs to determine the child's concept of telling the truth and lies. The worker should ask the child to describe the meaning of truth and the consequences of telling lies. If the child clearly does not have the concepts of truths and lies, the worker should continue the interview, but with caution.

4.12.11 Initiate free narrative

Introduce the topic of concern asking open-ended questions allowing the child to talk in a free narrative. Allow the child to go at his or her own pace. Do not interrupt the child. The child may be prompted by the worker by asking: "What happened next?" or "You were saying—relate the last thing they were saying." Do not interrupt the child no matter how verbose or inconsistent the story.

4.12.12 Ask open-ended questions

After the child has exhausted his or her free narrative for one incident the worker may begin to ask open-ended questions. This will enable the worker to assist the child in recalling more details. If the child discloses a new incident, the worker should again allow the child to talk in the free narrative style about the new incident. Then begin the process of the open-ended questions again. An example of an open-ended question is: Do you remember any more about the time it happened in the kitchen?

When the worker is asking open questions, it is absolutely imperative that the child knows that, "I don't remember" is an acceptable answer.

4.12.13 Keep track of multiple incidents or allegations

Should the child disclose several incidents of abuse the worker may want to label them so that the worker can refer the child back to them in order to get more detail. (Labeling incidents should become readily apparent for example where the incident occurred may provide a label, i.e., the kitchen incident or the park incident.)

4.12.14 Use specific questions

The CPS worker may use specific questions. This would clarify and extend previous answers. This form of questioning is used when previous types of questioning have not resulted in getting sufficient information to assess the credibility of the allegations.

4.12.15 Avoid multiple choice questions

The CPS worker should avoid multiple choice questions, but if you must use this type of question, include more than two choices. For example, did the park incident happen in the fall, winter, spring, or summer?

4.12.16 Avoid using other sources when asking questions

The CPS worker should never include information he/she has obtained from another source. For example, do not begin a question with, “I understand from your mother that your Uncle Sam took some pictures of you.” If you have been informed that the child was photographed, yet that information has not been forthcoming in the child’s free narrative or during open questioning, you may ask, “Do you remember anything about some pictures?”

4.12.17 Address inconsistencies toward end of interview

The CPS worker should address any inconsistencies in the child’s statement toward the end of the interview. This is an area of questioning that should be approached cautiously and gently. If the child displayed language and/or knowledge that seems inappropriate for his or her age, this would be the time to determine where the child learned that knowledge of those words.

4.12.18 Ending the interview

The worker should ask the child if he or she has any questions. The worker should explain to the child what will happen next in the investigation process.

4.12.19 Storing audio tapes

- Once the audio tape has been made, the worker should ensure it is properly labeled, as indicated earlier, then place the tape in an envelope, label the

envelope with the case name, seal the envelope, and secure it to the case record.

- Tapes are to be stored in the case record for the same length of time as CPS policy requires for other case documentation. For example, in unfounded cases, tapes must be retained for one year from the complaint date. Tapes are required to be retained for longer periods in founded cases. (Level 3 – three years, Level 2 – seven years, and Level 1 – 18 years).

4.12.20 Who can receive copies of the taped interviews?

- Interviews with the victim child can only be released during the appeals process. If a copy of the audio tape is needed, based on CPS policy governing the release of information during the appeal process, it must be determined if any statutorily protected information is contained on the tape. If so, a duplicate tape will be needed. (The original tape must never be redacted.) Identification of the area(s) to be edited, indicated by tape counter number(s), must be provided to the entity copying the tape. As an option, the LDSS may wish to type a transcript of the tape. This is not a requirement, however.

- Audio taped interviews with the alleged abuser can be duplicated by the LDSS by playing the audio tape on one tape recorder while recording the tape on a second tape recorder. LDSS also have the option of typing a transcript of the interview.

4.12.21 Redacting/editing sensitive information from a tape

The VDSS is investigating the option of entering into a contract with a professional service to copy and/or redact (edit) audio tapes. Should this occur, procedures will be developed and distributed to all LDSS. Until that time, the LDSS is responsible for the editing of duplicate tapes. The original tape must never be edited.

The worker is the most knowledgeable about the content of the tape and is therefore the most logical individual to edit the duplicate tape.

4.12.22 Reuse of audio tapes

Audio tapes are never to be reused. This would potentially compromise the tape being reused by possibly having the earlier interview “bleed through” on the next interview. It would also pose a privacy protection issue by having confidential tapes available for further use.

4.12.23 Destruction of used tapes

Once the length of time has passed for retaining the case record, from one to 18 years, depending on the disposition of the investigation, the audio tape(s) must be destroyed. A tape eraser box will be provided to each agency in order for tapes to be erased. Once erased, the tape cassettes should be broken, or the tape cut in order to ensure the complete eradication of information on the tape. Some tape recorders have an 'erase' feature that will void the information on the tape. This should be tested, however, to ensure it is actually erasing the tape.

4.13 Appendix B: How to proceed with investigation when initial entry into the home is denied

4.13.1 Authority

The worker has the authority to enter the home if permitted to enter by a person who resides in the home.

4.13.2 Alleviate fear, anxiety, anger

The CPS worker should try to alleviate the fear and anxiety of the occupant, and/or defuse any anger. It is not appropriate to engage in a power struggle.

4.13.3 Alternatives to immediate entry

Should the CPS worker be denied entry, the CPS worker has several options:

- The CPS worker may suggest the occupant speak with them on the porch, deck, or in the yard, or even through the door, while at the same time acknowledging the feelings of the occupant (anger, fear, suspicion) in his reluctance to allow entry.
- The CPS worker may explain the law and the parameter of their responsibilities and mandates, and ask the occupant how the CPS worker may alleviate the skepticism or fear of the occupant so that then or in the future the CPS worker may be allowed to enter.
- The CPS worker may invite the occupant and any person of his choice (including an attorney) to meet with him first at the local DSS office, to further explain the CPS system.
- The CPS worker may suggest a first meeting at a neutral spot, such as a local fast-food restaurant, or other public place.
- The CPS worker may suggest a first meeting at a friend or family member's home, or a meeting in the occupant's home when a friend, neighbor, or family member is present.
- The CPS worker may suggest mediation with the occupant to negotiate entry.
- The CPS worker may contact his supervisor for direction.
- The CPS worker may follow up a denial of entry with a letter citing the Virginia Code responsibilities.

4.14 Appendix C: Guidelines for investigations where children are alleged to be present during the sale or manufacture of drugs

The intent of adding a clause to the definition of physical abuse, which was enacted by the General Assembly 2004, is to give recognition to the danger for children when a caretaker exposes the child to the manufacture or sale of drugs. The additional language in the definition references Schedule I & II controlled substances, which include, but are not limited to heroin, cocaine, and methamphetamines. The Code of Virginia §§ 54.1-3446 and 54.1-3448 provide a list of Schedule I and II controlled substances.

There is reason to be concerned about both the safety of the child and the CPS worker when there is the possibility that a "meth lab" is on the premises. The vapors may attack mucous membranes and some chemicals may react with water or other chemicals to cause a fire or explosion.

Since these situations may be dangerous, it is imperative that the LDSS collaborate with local law enforcement and emergency services. CPS should not be the first on the scene if there is reason to believe someone may be manufacturing drugs on the premises. The following is a sample protocol developed by a locality in North Carolina that has experienced a large number of "meth lab" situations. It is offered for your consideration in developing your own local protocol.

Response Protocol For Children Found In Clandestine Drug Lab Situations Adopted by the Watauga County (North Carolina) Drug Endangered Child Program on April 2, 2004

1. In the event that a Clandestine Lab is about to be raided and there is a possibility of children in the residence law-enforcement will contact the Watauga County Department of Social Services to begin preparations for responding to the scene if children are found.

2. Watauga County DSS will place two service workers on standby prepared to respond to the scene if a lab is found and children are present.

3. After law-enforcement verifies a lab is found in a residence and children are present they will then contact Watauga County DSS to respond to the scene. Watauga County DSS will respond immediately.

4. Watauga County DSS will contact the Watauga County Fire Marshal's Office to report to the scene to assist in assessing for the need of on-site decontamination of the children.

5. The Watauga County Fire Marshal and Watauga County DSS will determine if decontamination on scene is needed by using The Decontamination Field Assessment.

5A. If decontamination is needed on the scene for the children the Watauga County Fire Marshal will coordinate the needed procedures based on where the scene is in the county.

6. If decontamination is needed on scene and possibly if not needed Watauga County DSS will provide a change of clothes for the child.

7. Watauga County DSS will make a determination of whether a child needs to be placed into protective custody or if a placement with a safety agreement can be used.

7A. Placement in the home where a lab was found cannot occur under any circumstance until the home is cleaned, tested, and decontaminated using State prepared guidelines.

7B. The child will not be allowed to have contact with any item that was in the home where a meth lab was found due to contamination concerns.

8. After decontamination has been assessed or done the child will be transported to Watauga Medical Center for evaluation. Watauga County Medical Center requires decontamination at the emergency room prior to the child entering the hospital. Transportation will be provided either by Watauga County DSS, relative, or EMS (if there is a medical concern). The transportation concern will be assessed on a case-by-case basis.

8A. If the child is located at the scene and has been in the home within the past 72 hours or is displaying medical concerns the child does need to be taken to Watauga Medical Center for first or secondary decontamination and evaluation.

8B. If the child has not been in the home where the meth lab was located within the past 72 hours the child can be taken to their pediatrician for evaluation. 8B would be used in cases where the child was not found at the scene but was known to be living there and cases where the child has been out of the home for 72 hours. Also, 8B would be used in cases where children were found to be in the home with the lab but were unknown at the time the meth lab was found and 72 hours is passed.

8C. Someone with legal custody must be present at the emergency room or pediatrician office to sign for medical checks to be done. If parents are arrested then DSS may have to take custody to authorize medical evaluations.

9. Watauga County DSS will provide the physician at the Medical Center being used with a copy of the Medical Protocol developed by the Drug Endangered Child Program.

9A. Service workers will need to make sure they get a copy of the Medical Protocol back after evaluations have completed. With each test that has been completed document the form. This is done so that service workers can provide information at the follow-up evaluations as to what testing was done for comparison data.

9B. All drug testing evidence will follow the chain of custody between physician/medical office and the drug testing lab they use.

10. After the child is released from the medical center the following steps will take place:

10A. If DSS is not taking custody and using a Safety Plan a service worker will need to go to the placement resource and conduct the Kinship Care Assessment before allowing the child to stay there. This will also be done if DSS takes custody and places the child with a relative. Service Workers will explain to the foster placement all of the details as to what the child has been through. Service workers will also explain all the items that will be taking place in the future.

10B. If DSS takes custody of the child and is not using a relative placement the foster placement will be decided at this time. Service Workers will explain to the foster placement all of the details as to what the child has been through. Service Workers will also explain all the items that will be taking place in the future.

11. Watauga County Department of Social Services accepts all cases where children are alleged to be in homes with meth labs as abuse. As soon as possible Watauga County DSS will submit written notification to the District Attorney a report of abuse.

12. Other steps that will be taken are:

- All the child's belongings will be replaced to protect from repeated contamination.
- The child will receive counseling services either through Individual Counseling, Family Counseling, or Family Preservation. Determination of which or all of the services to be used will be made on a case-by-case basis.
- The parents involved in meth lab production with their children present will take part in a Meth Lab Hazard Training provided by the Watauga County Fire Marshal. This needs to be done prior to any Substance Abuse Assessment.
- The parents will be required whether they are incarcerated or not to take part in a complete Substance Abuse Evaluation and follow all recommendations. If possible it is preferred that there be A Family Substance Abuse Assessment that includes the children. Use of the Family Substance Abuse Assessment will be determined based on relationship between child and parent and age of the child.
- Parents will have to take part in drug screens at DSS request and at the Substance Abuse Treatment provider's request.
- Children age 3 and under will need to have Developmental Evaluations performed.

- The child will need a follow-up medical evaluation at or around 30 days from the initial evaluation that was completed. At this evaluation hair samples will be taken if urine screens were negative at the initial medical evaluation.

Members of the response team:

Watauga County Department of Social Services
Watauga County Sheriff's Department
New River Behavioral Health Care Substance Abuse Services
New River Behavioral Health Care Family Preservation
Watauga County Schools
The Watauga County Developmental Evaluation Center
New River Behavioral Health Care PACT Program
Blue Ridge Pediatric Clinic
Northwestern Housing HUD
Watauga County Office of Juvenile Justice
Watauga County Fire Marshal
Mountain Times Newspaper
Watauga County District Attorney's Office
Watauga County Medical Center Emergency Room Staff
Watauga County Medical Center Infectious Disease Control
Watauga County EMS
Watauga County Health Department Early Childhood Intervention
Watauga County Health Department of Environmental Sciences
The Guardian ad Litem Program
Watauga County Foster Parents Representatives
Forensic Toxicologist Dr. Andrew Mason

4.15 Appendix D: CPS Safety Tool

VIRGINIA DEPARTMENT OF SOCIAL SERVICES r: 07/11
SAFETY ASSESSMENT

OASIS Referral Name: _____ **Worker Name:** _____ **Supervisor:** _____

FIPS Code: _____ **Status:** ___ Investigation ___ Assessment **Safety Assessment Completion Date:** _/____/____

☐ **Alternative Caretaker Household**
Please check either Investigation/Assessment or Open Case and fill out the corresponding section.

☐ **Investigation/Assessment**
Referral #: _____ **Check one:** ____ Initial ____ Review # 1 2 3 4 ___
Referral Date: ____/_____/_____ **Alleged Perpetrator:** _____

☐ **Open Case**
Case #: _____ Review # 1 2 3 4 ___

Factors Influencing Child Vulnerability (conditions that result in child's inability to protect self; check any factor that applies to any child)

_____ Age 0–6
_____ Diminished physical capacity (e.g., uses wheelchair)
_____ Diminished mental capacity (e.g. intellectual disability)
_____ Any child has exceptional medical or emotional condition
_____ Any child is of school age, but is not attending school

SECTION 1: SAFETY FACTOR IDENTIFICATION
Directions: The following list of factors are behaviors or conditions that may be associated with a child being in **immediate** danger of serious harm. Identify the presence or absence of each factor by checking yes or no. Check yes if the factor applies to any child in the household. The assessment shall cover all children in the home and all others present. The focus of the assessment is on conditions that exist at the time of the assessment.

☐ **Yes** ☐ **No** 1. **Caretaker caused serious physical harm to the child and/or made a plausible threat to cause physical harm in the current investigation/assessment. (Check yes if any one of the following apply. Check all that apply.)**

_____ a. Death of a child.
_____ b. Serious injury or abuse to child other than accidental.
_____ c. Caretaker committed act that placed child at risk of significant/serious pain that could result in impairment or loss of bodily function.
_____ d. Threat to cause harm or retaliate against child.
_____ e. Excessive physical discipline or physical force.
_____ f. Immediate threatened harm as a result of child's proximity to domestic violence incident.
_____ g. One or more caretakers fear they will maltreat child.
_____ h. Drug-exposed infant.
_____ i. Caretaker intended to hurt child and does not show remorse.

Comments: _____

_____

☐ **Yes** ☐ **No** 2. **Caretaker has previously maltreated a child in his/her care and the severity of the maltreatment or the caretaker's response to the previous incident AND current circumstances suggest that child's safety may be an immediate concern.** (If caretaker previously maltreated a child, check below all circumstances that apply. The fact of prior involvement does not necessarily mean there is a safety issue now.)

_____ a. Prior death of a child.
_____ b. Prior serious harm to any child.
_____ c. Termination of parental rights.
_____ d. Prior removal of any child.
_____ e. Prior CPS founded allegation or supported assessment.
_____ f. Prior threat of serious harm to child.
_____ g. Caretaker failed to benefit from previous professional help.

Comments: _____

_____

☐ Yes ☐ No 3. **Caretaker fails to protect child from serious physical harm or threatened harm by others.**

_____ a. Caretaker fails to protect child from serious harm or threatened harm by other family members, other household members, or others having regular access to the child.

_____ b. An individual(s) with recent, chronic, or severe violent behavior resides in the home, or caretaker allows access to the child.

Comments: _____

_____

☐ Yes ☐ No 4. **Caretaker's explanation for the injury to the child is questionable or inconsistent with the type of injury, and the nature of the injury suggests that the child's safety may be of immediate concern.**

_____ a. Medical exam shows injury is the result of abuse; caretaker gives no explanation, denies, or attributes to accident.

_____ b. Caretaker's explanation for the observed injury is inconsistent with the type of injury.

_____ c. Caretaker's description of the cause of the injury minimizes the extent of harm to the child.

_____ d. Caretaker's and/or collateral contacts' explanation for the injury has significant discrepancies or contradictions.

Comments: _____

_____

☐ Yes ☐ No 5. **The family is refusing access to the child, there is reason to believe that the family is about to flee, or the child's whereabouts cannot be ascertained.**

_____ a. Family currently refuses access to the child and cannot or will not provide child's location.

_____ b. Family removed the child from a hospital against medical advice.

_____ c. Family has previously fled in response to a CA/N investigation/assessment.

_____ d. Family has history of keeping the child away from peers, school, or other outsiders for extended periods to avoid investigation/assessment.

_____ e. Family is otherwise attempting to block or avoid investigation/assessment.

Comments: _____

_____

☐ Yes ☐ No 6. **Child is fearful of caretaker, other family members, or people living in or having access to the home.**

_____ a. Child cries, cowers, cringes, trembles, or exhibits or verbalizes fear in relation to certain individuals.

_____ b. Child exhibits anxiety, nightmares, or insomnia related to a situation associated with a person in the home.

_____ c. Child fears unreasonable retribution/retaliation from caretaker, others in the home, or others having access to the child.

Comments: _____

_____

☐ Yes ☐ No 7. **Caretaker fails to provide supervision necessary to protect child from potentially serious harm.**

_____ a. Caretaker present but child wanders outdoors alone, plays with dangerous objects or on window ledges, etc.

_____ b. Caretaker leaves child alone (period of time varies with age and developmental status).

_____ c. Caretaker makes inadequate/inappropriate child care arrangements or plans very poorly for child's care.

_____ d. Caretaker's whereabouts are unknown.

Comments: _____

_____

☐ Yes ☐ No 8. **Caretaker fails to meet the child's immediate needs for food, clothing, shelter, and/or medical and/or mental health care.**

_____ a. No housing/emergency shelter; child must sleep in the street, car, etc.; housing is unsafe, without heat/water, etc.
_____ b. No food provided or available to the child, or child is starved/deprived of food/drink for long periods.
_____ c. Child is without minimally warm clothing in cold months.
_____ d. Caretaker does not seek treatment for child's immediate medical condition(s) or does not follow prescribed treatments.
_____ e. Child appears malnourished.
_____ f. Child has exceptional needs that parents cannot/will not meet.
_____ g. Child is suicidal and parents will not take protective action.
_____ h. Child shows effects of maltreatment (e.g., emotional symptoms, lack of behavior control, or physical symptoms).

Comments: _____

_____

☐ Yes ☐ No 9. **Child's physical living conditions are hazardous and immediately threatening, based on the child's age and developmental status.**

_____ a. Leaking gas from a stove or heating unit.
_____ b. Dangerous substances or objects stored in unlocked lower shelves or cabinets, under sink, or in the open.
_____ c. Lack of water, heat, plumbing, or electricity, or provisions are inappropriate (e.g., stove/space heaters).
_____ d. Open/broken/missing windows.
_____ e. Exposed electrical wires.
_____ f. Excessive garbage or rotted or spoiled food that threatens health.
_____ g. Serious illness/significant injury due to current living conditions (e.g., lead poisoning, rat bites, etc.).
_____ h. Evidence of human or animal waste throughout the living quarters.
_____ i. Guns and other weapons are not stored in a locked or inaccessible area.
_____ j. Dangerous drugs are being manufactured on premises with child present.

Comments: _____

_____

☐ Yes ☐ No 10. **Caretaker's substance use is currently and seriously affecting his/her ability to supervise, protect, or care for child.**

_____ a. The caretaker is currently high on drugs or alcohol.
_____ b. There is a current, ongoing pattern of substance abuse that leads directly to neglect and/or abuse of the child.

Comments: _____

_____

☐ Yes ☐ No 11. **Caretaker's behavior towards the child is violent or out of control.**

_____ a. Behavior that seems to indicate a serious lack of self-control (e.g., reckless, unstable, raving, explosive).
_____ b. Caretaker uses brutal or bizarre punishment (e.g., scalding, burning with cigarettes, forced feeding, killing or torturing pets as punishment).
_____ c. Extreme action/reaction (e.g., physical attacks, violently shaking or choking).
_____ d. Use of guns, knives, or other instruments in a violent and/or out-of-control manner.

Comments: _____

_____

☐ Yes ☐ No **12. Caretaker describes or acts towards the child in predominantly negative terms or has unrealistic expectations, and this has a major impact on the child (e.g., severely withdrawn).**

_____ a. Caretaker repeatedly describes child in a demeaning or degrading manner (e.g., as evil, possessed, stupid, ugly, etc.).
_____ b. Caretaker repeatedly curses and/or puts child down.
_____ c. Caretaker repeatedly scapegoats a particular child in the family.
_____ d. Caretaker repeatedly blames child for a particular incident, or distorts child's behavior as a reason to abuse.
_____ e. Caretaker repeatedly expects unrealistic behavior(s) per child's age/developmental stage.
_____ f. Caretaker views child as responsible for the caretaker's or family's problems.

Comments: _____

_____

☐ Yes ☐ No **13. Child sexual abuse is suspected and circumstances suggest that child safety is an immediate concern.**

_____ a. Caretaker or other(s) in the household has committed rape, sodomy, or other sexual contact with the child.
_____ b. Child forced/encouraged to engage in sexual performances or activities.
_____ c. Access to a child by possible or confirmed sexual abuse perpetrator exists.

Comments: _____

_____

☐ Yes ☐ No **14. Caretaker's physical, intellectual, or mental health seriously affects his/her current ability to supervise, protect, or care for the child.**

_____ a. Caretaker has a physical condition that seriously impairs his/her ability to parent the child.
_____ b. Emotional instability, acting out, or distorted perception is seriously impeding ability to parent.
_____ c. Depression or feelings of hopelessness/helplessness immobilize the caretaker, who then fails to maintain child/home.
_____ d. Caretaker is overwhelmed by child's dysfunctional emotional, physical, or mental characteristics.
_____ e. Caretaker's cognitive delays result in lack of knowledge about basic parenting skills.

Comments: _____

_____

☐ Yes ☐ No **15. Other safety factors (specify):** _____

_____

IF THERE ARE NO SAFETY FACTORS PRESENT, GO TO SECTION 3 AND CHECK "SAFE."

SECTION 2: SAFETY RESPONSE—PROTECTING INTERVENTIONS

For each safety factor identified in Section 1, consider the resources available to the family and the community that might help to keep the child safe. Check each protecting intervention taken to protect the child and explain below. Describe all protecting safety interventions taken or immediately planned by you or anyone else, and explain how each intervention protects (or protected) each child.

_____ 1. Monitoring or direct services by social worker.

_____ 2. Use of family resources, neighbors, or other individuals in the community in the development and implementation of a safety plan.

_____ 3. Use of community agencies or services as a safety resource (specify agency or resource): _____

_____

_____ 4. Alleged offender left the home:

_____ Voluntarily
_____ In response to police intervention
_____ Legal action
_____ Other: _____

_____ 5. Non-maltreating caretaker moved to a safe environment with his/her child.

_____ 6. Caretaker placed child outside the home (specify): _____

_____ 7. Legal action initiated; child remains in the home (explain in summary)
_____ PPO _____ Other, specify: _____

_____ 8. Other intervention to allow child to remain in the home: _____

_____ 9. Ex parte order (summary or ERO) was requested to remove child from home due to immediate safety issues.

_____ Granted: (date and time) _____/_____/_____ _____:_____ a.m./p.m.
_____ Denied: (date and time) _____/_____/_____ _____:_____ a.m./p.m.

_____ 10. Police intervention: _____ Yes _____ No

Incident was reported to assistance requested from _____ Police Department

Date: _____/_____/_____ _____:_____ a.m./p.m. To: _____

SECTION 3: SAFETY DECISION

Identify your safety decision by checking the appropriate line. Check only one. This decision should be based on the assessment of all safety factors, protecting interventions, and any other information known about the case. "Safe" should be checked only if no safety factors were identified in Section 1, Safety Factor Identification.

_____ 1. **Safe:** There are no children likely to be in immediate danger of serious harm.

_____ 2. **Conditionally safe:** Protective safety interventions have been taken and have resolved the unsafe situation for the present time. These interventions are included in the attached safety plan.

_____ 3. **Unsafe:** Approved removal and placement was the only possible intervention for the child. Without placement, the child will likely to be in danger of immediate or serious harm. See attached safety plan or court order.

Comments: _____

_____

If decision is "unsafe" and any of the children are left in the home, explain why: _____

_____

4.15.1 SDM® Safety Assessment definitions

1. **Caretaker caused serious physical harm to the child and/or made a plausible threat to cause physical harm in the current investigation/assessment.**

    a. Death of a child. This incident resulted in the death of one or more children.

    b. Serious injury or abuse to child other than accidental. Caretaker caused serious injury, defined as brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocations, sprains, internal injury, poisoning, burns, scalds, or severe cuts. Also include any other physical injury that seriously impairs the health or well-being of the child (e.g., suffocating, shooting, bruises/welts, bite marks, choke marks) and requires medical treatment.

    c. Caretaker committed act that placed child at risk of significant/serious pain that could result in impairment or loss of bodily function.

    d. Threat to cause harm or retaliate against child. Threat of action that would result in serious harm; or household member plans to retaliate against child for CPS investigation/assessment.

    e. Excessive physical discipline or physical force. Caretaker has used torture or excessive physical force, or acted in a way that bears little resemblance to reasonable discipline given the child's age and stage of development; or caretaker punished child beyond the duration of the child's endurance. Examples include punching child in head or stomach, tying child up, locking child in a closet, slamming child against wall, or punishing child in a way that produces humiliation or degradation; or punishing child for acts that are outside child's control.

    f. Immediate threatened harm as a result of child's proximity to domestic violence incident. Child was in immediate danger of serious physical harm by being in close proximity to an incident(s) of assaultive behavior/domestic violence between adults in the household.

    g. One or more caretakers fear they will maltreat child and/or requests placement.

    h. Drug-exposed infant. Drugs are found in the child's system; infant is medically fragile as result of drug exposure; infant suffers adverse

effects from introduction of drugs during pregnancy; or mother tested positive at delivery.

i. Caretaker intended to hurt child and does not show remorse. Caretaker's intention in the current incident was to inflict pain/injury on the child and the caretaker does not express remorse for this action.

2. Caretaker has previously maltreated a child in his/her care and the severity of the maltreatment or the caretaker's response to the previous incident AND current circumstances suggest that child's safety may be an immediate concern.

Note: This item requires three conditions to answer "yes." First, there must have been one or more **previous** incidents of maltreatment reported to child welfare. Second, that maltreatment must have been severe OR the caretaker's response to the previous maltreatment was inappropriate (e.g., dismissive, minimizing, failure to take recommended safety steps). Third, there must be **current** circumstances that, considered in light of the prior incidents, indicate there are safety issues now. In other words, the fact of prior maltreatment does not necessarily mean that this safety factor should be checked "yes."

Check all characteristics of **prior** maltreatment that apply to this case, whether or not this item is currently a safety issue.

a. Prior death of a child as a result of maltreatment.

b. Prior serious harm to any child. Previous maltreatment by caretaker that was serious enough to cause severe injury (e.g., fractures, poisoning, suffocating, shooting, burns, bruises/welts, bite marks, choke marks, and/or physical findings consistent with sexual abuse based on medical exam).

c. Termination of parental rights. Caretaker had parental rights terminated as a result of a prior CPS investigation/assessment.

d. Prior removal of any child. Removal/placement of child by CPS or other responsible agency or concerned party was necessary for the safety of child.

e. Prior CPS founded allegation or supported assessment. Prior CPS investigation/assessment founded for maltreatment or supported assessment.

f. Prior threat of serious harm to child. Previous maltreatment that could have caused severe injury; retaliation/threatened retaliation for previous

incidents; prior domestic violence that resulted in serious harm or threatened harm to a child.

g. Caretaker failed to benefit from previous professional help. Caretaker previously maltreated a child in his/her care and was referred for professional services as a result, but did not participate in or did not benefit from those services.

3. Caretaker fails to protect child from serious physical harm or threatened harm by others.

a. Caretaker fails to protect child from serious harm or threatened harm by other family members, other household members, or others having regular access to the child. Caretaker does not provide supervision necessary to protect child from potential serious harm by others, based on the child's age or developmental stage. Harm includes physical abuse, neglect, or sexual abuse.

b. An individual(s) with recent, chronic, or severe violent behavior resides in the home, or caretaker allows access to the child.

4. Caretaker's explanation for the injury to the child is questionable or inconsistent with the type of injury, and the nature of the injury suggests that the child's safety may be of immediate concern.

a. Medical exam shows injury is the result of abuse; caretaker gives no explanation, denies, or attributes to accident. Medical evaluation indicates injury is non-accidental; caretaker denies or attributes injury to accidental causes.

b. Caretaker's explanation for the observed injury is inconsistent with the type of injury.

c. Caretaker's description of the cause of the injury minimizes the extent of harm to the child.

d. Caretaker's and/or collateral contacts' explanation for the injury has significant discrepancies or contradictions. There are significant discrepancies between what the caretaker says and what other contacts say about the cause of the injury.

5. The family is refusing access to the child, there is reason to believe that the family is about to flee, or the child's whereabouts cannot be ascertained.

a. Family currently refuses access to the child or cannot or will not provide child's location.

b. Family removed the child from a hospital against medical advice to avoid investigation / assessment.

c. Family has previously fled in response to a CA/N investigation / assessment.

d. Family has history of keeping the child away from peers, school, or other outsiders for extended periods to avoid investigation/assessment.

e. Family is otherwise attempting to block or avoid investigation / assessment.

6. Child is fearful of caretaker, other family members, or people living in or having access to the home.

a. Child cries, cowers, cringes, trembles, or exhibits or verbalizes fear in relation to certain individuals.

b. Child exhibits anxiety, nightmares, or insomnia related to a situation associated with a person in the home.

c. Child fears unreasonable retribution/retaliation from caretaker, others in the home, or others having access to the child.

7. Caretaker fails to provide supervision necessary to protect child from potentially serious harm.

a. Caretaker present but child wanders outdoors alone, plays with dangerous objects or on window ledges, etc.

b. Caretaker leaves child alone (period of time varies with age and developmental status).

c. Caretaker makes inadequate/inappropriate child care arrangements or plans very poorly for child's care.

d. Caretaker's whereabouts are unknown.

8. Caretaker fails to meet the child's immediate needs for food, clothing, shelter, and/or medical and/or mental health care.

a. No housing/emergency shelter; child must sleep in the street, car, etc.; housing is unsafe, without heat/water, etc.

b. No food provided or available to the child, or child is starved/deprived of food/drink for long periods.

c. Child is without minimally warm clothing in cold months.

d. Caretaker does not seek treatment for child's immediate medical condition(s) or does not follow prescribed treatments.

e. Child appears malnourished or has been diagnosed as non-organic failure to thrive.

f. Child has exceptional needs that parents cannot / will not meet. Needs include being medically fragile.

g. Child is suicidal and parents will not take protective action.

h. Child shows effects of maltreatment (e.g., emotional symptoms, lack of behavior control, or physical symptoms).

9. Child's physical living conditions are hazardous and immediately threatening, based on the child's age and developmental status.

Based on the child's age and developmental status, the child's physical living conditions are hazardous and immediately threatening, including but not limited to the following:

a. Leaking gas from a stove or heating unit.

b. Dangerous substances or objects stored in unlocked lower shelves or cabinets, under sink, or in the open.

c. Lack of water, heat, plumbing, or electricity, or provisions are inappropriate (e.g., stove/space heaters).

d. Open/broken/missing windows.

e. Exposed electrical wires.

f. Excessive garbage or rotted or spoiled food that threatens health.

g. Serious illness/significant injury due to current living conditions (e.g., lead poisoning, rat bites, etc.).

h. Evidence of human or animal waste throughout the living quarters.

i. Guns and other weapons are not stored in a locked or in accessible area.

j. Dangerous drugs are being manufactured on premises with child present.

10. Caretaker's substance use is currently and seriously affecting his/her ability to supervise, protect, or care for child.

Caretaker is abusing legal or illegal substances or alcoholic beverages to the extent that control of his or her actions is significantly impaired.

a. The caretaker is currently high on drugs or alcohol.

b. There is a current, ongoing pattern of substance abuse that leads directly to neglect and/or abuse of the child.

11. Caretaker's behavior towards the child is violent or out of control.

Caretaker behavior is a serious potential threat to child, as indicated by the following:

a. Behavior that seems to indicate a serious lack of self-control (e.g., reckless, unstable, raving, explosive).

b. Caretaker uses brutal or bizarre punishment (e.g., scalding, burning with cigarettes, forced feeding, killing or torturing pets as punishment).

c. Extreme action/reaction (e.g., physical attacks, violent shaking or choking).

d. Use of guns, knives, or other instruments in a violent and/or out-of-control manner.

12. Caretaker describes or acts towards the child in predominantly negative terms or has unrealistic expectations, and this has a major impact on the child (e.g., severely withdrawn).

a. Caretaker repeatedly describes child in a demeaning or degrading manner (e.g., as evil, possessed, stupid, ugly, etc.).

b. Caretaker repeatedly curses and/or puts child down.

c. Caretaker repeatedly scapegoats a particular child in the family.

d. Caretaker repeatedly blames child for a particular incident, or distorts child's behavior as a reason to abuse.

e. Caretaker repeatedly expects unrealistic behavior(s) per child's age/ developmental stage. Caretaker repeatedly expects child to perform or act in a way that is impossible or improbable for the child's age or developmental stage (e.g., babies and young children expected not to

cry, expected to be still for extended periods, be toilet trained, eat neatly, or expected to care for younger siblings or stay alone).

f. Caretaker views child as responsible for the caretaker's or family's problems.

13. Child sexual abuse is suspected and circumstances suggest that child safety is an immediate concern.

Suspicion of sexual abuse may be based on indicators such as the following:

a. Caretaker or other(s) in the household has committed rape, sodomy, or other sexual contact with the child.

b. Child forced/encouraged to engage in sexual performances or activities. Caretaker or others in the household have forced or encouraged child to engage in sexual performances or activities (including forcing child to observe sexual performances or activities).

c. Access to a child by possible or confirmed sexual abuse perpetrator exists.

14. Caretaker's physical, intellectual, or mental health seriously affects his/her current ability to supervise, protect, or care for the child.

a. Caretaker has a physical condition that seriously impairs his/her ability to parent the child.

b. Emotional instability, acting out, or distorted perception is seriously impeding ability to parent.

c. Depression or feelings of hopelessness/helplessness immobilize the caretaker, who then fails to maintain child/home.

d. Caretaker is overwhelmed by child's dysfunctional emotional, physical, or mental characteristics.

e. Caretaker's cognitive delays result in lack of knowledge about basic parenting skills. Due to cognitive delay, the caretaker lacks the basic knowledge related to parenting skills, such as the following:

1) Knowing that infants need regular feedings;
2) Fails to access and obtain basic/emergency medical care;
3) Knowledge of proper diet; or
4) Adequate supervision.

15. Other safety factors

This item should be used if there are other immediate safety issues not identified above. Any "other" factors require a brief narrative description of the circumstances or conditions that constitute a threat.

4.15.2 Safety Assessment procedures

The purpose of the safety assessment and plan is to 1) help assess whether any children are currently in immediate danger of serious physical harm that may require a protecting intervention, and 2) to determine what interventions should be maintained or initiated to provide appropriate protection.

Risk versus safety assessment. It is important to keep in mind the difference between safety and risk when completing this form. Safety assessment differs from risk assessment in that it assesses the child's present danger and the interventions currently needed to protect the child. In contrast, risk assessment looks at the likelihood of future maltreatment.

Which Cases:

- All referrals that are assigned for investigation/assessment.
- New referrals on currently active cases.
- Any open referrals or cases in which changing circumstances require an assessment of safety due to the following:
  - Change in family circumstances.
  - Change in information known about the family.
  - Change in ability of safety interventions to mitigate safety factors.

Who: The service worker who makes the initial response to the referral. For open cases, the service worker with responsibility for the case.

When: Safety assessment is both a process and a document. Safety assessment is an ongoing process throughout the life of a case. A worker completes a safety assessment process before concluding each face-to-face contact. Documentation of the safety assessment using the SDM tool is created to reflect safety status at certain points (create a new safety assessment when documenting changes to safety instead of amending the initial safety assessment as it is critical to maintain a decision-

making trail):

- **Within 24 hours** of concluding the first face-to-face contact.
- **Within 24 hours** of any subsequent contact in which there was a change in safety status:
  - One or more safety factors previously present are no longer present.
  - One or more safety factors not present before are present now.
  - Changes to safety plan and/or safety decision.

Prior to placing a child with a non-custodial parent, relative, or interested individual. This also pertains to voluntary placements when the parent is placing a child. (**Note**: These safety assessments should be clearly recorded as pertaining to a household other than the household under investigation by checking "Alternative Caretaker Household.")

Decisions: The safety assessment provides structured information concerning the danger of immediate harm/maltreatment to a child. This information guides the decision about whether the child may remain in the home with no intervention, may remain in the home with safety interventions in place, or must be protectively placed.

A safety intervention is required for all children when any safety factor has been identified.

Appropriate Completion: If this is a fatality AND there are no other children in the home, check "safe".

Workers should familiarize themselves with the items that are included in the safety assessment and accompanying definitions. Once a worker is familiar with the items on the safety assessment, the worker should conduct initial contact as he/she normally would, using good social work practice to collect information from the child, caretaker, and/or collateral sources. The worker is assessing safety conditions in the home (e.g., if child is hospitalized, assess the safety of the home not the hospital setting.)

Indicate (check) whether any child vulnerabilities are present. Consider these vulnerabilities when reviewing safety items. Note that these vulnerability issues provide a context for safety assessment. The presence of one or more vulnerabilities does not automatically mean that the child is unsafe.

All safety factor responses must have a written rationale and description if the response is "yes." All rationales must be specific to the family situation (do not simply quote the definition).

All children who are household members are included in a safety assessment.

The safety assessment consists of three parts:

Section 1: Safety Factor Identification. This is a list of critical factors that must be assessed by every worker in every case. These factors cover the kinds of conditions that, if they exist, would render a child in danger of immediate harm. Because not every conceivable safety factor can be anticipated or listed on a form, an "other" category permits a worker to indicate that some other circumstance creates a safety factor; that is, there is something other than the listed categories that causes the worker to believe that the child is in danger of being harmed now.

The safety factors have a series of sub-items listed. These sub-items serve as definitional guidelines and as illustrations of conditions that would warrant answering "yes" for that safety factor. However, they are not exhaustive of the conditions that could warrant a "yes" response. If one of the listed sub-items is present in the case, it should be checked and the safety factor should be scored as "yes." If some other serious (but unlisted) condition exists that meets the threshold for severity indicated by the safety factor language and the listed sub-items, it should be described briefly in the space provided below that safety factor, and "yes" should be checked.

For this section, rely on information available at the time of the assessment. Workers should make every effort to obtain sufficient information to assess these items prior to terminating their initial contact. However, it is not expected that all facts about a case can be known immediately. Some information may

be inaccessible and some may be deliberately hidden from the worker. Based on reasonable efforts to obtain information necessary to respond to each item, review each of the safety factors and accompanying definitions. For each item, consider the most vulnerable child. If the safety factor is present, based on available information, check "yes." If the safety factor is not present, check "no." If there are circumstances the worker determines constitute a safety factor, and these circumstances are not described by one of the existing items, the worker should check "other" and briefly describe the factor.

If it is suspected that there are safety issues in relation to a particular factor, but there is little/no evidence to support the suspicion, check "no," but clearly specify the concerns in the narrative section.

Section 2: Safety Response—Protecting Interventions. This section is completed only if one or more safety factors were identified. If one or more safety factors are present, it does not automatically follow that a child must be placed. In many cases, it will be possible for a temporary plan to be initiated that will mitigate the safety factors sufficiently so that the child may remain in the home while the investigation/assessment continues. Consider the relative severity of the safety factor(s), the caretaker's ability and willingness to work toward solutions, the availability of resources, and the vulnerability of the child.

The safety intervention list is made up of general categories of interventions rather than specific programs. The worker should consider each potential category of intervention and determine whether that intervention is available and sufficient to mitigate the safety factor(s) and whether there is reason to believe the caretaker will follow through with a planned intervention. Simply because an intervention exists in the community does not mean it should be used in a particular case. The worker may determine that even with an intervention the child would be unsafe; or the worker may determine that an intervention would be satisfactory, but has reason to believe the caretaker would not follow through. Also keep in mind that the safety intervention is not the service plan—it is not intended to "solve" the household's problems or provide long-term answers. A safety intervention permits a child to remain home during the course of the investigation/assessment.

If one or more safety factors were identified and the worker determines that interventions are unavailable, insufficient, or may not be used, the final option is to indicate that child will be placed.

If one or more interventions will be implemented, mark each category that will be used. If there is an intervention that will be implemented that does not fit the other categories, mark intervention #8 and briefly describe the intervention. Intervention #9 is used only when a child is unsafe and only a placement can ensure safety. Intervention #10 should be completed whenever staff have requested assistance from the police.

Section 3: Safety Decision. In this section, the worker records the result of the safety assessment. There are three choices:

a. **Safe.** Check this line if **no** safety factors were identified. The SDM system guides the worker to leave the child in the home. If this is a fatality AND there are no other children in the home, assessment is "safe" as safety pertains to immediate danger of harm to child (**Note**: This may require worker to uncheck #1).

b. **Conditionally safe.** If one or more safety factors were identified and the worker was able to identify sufficient protective interventions that lead him/her to believe the child may remain in the home for the present time, this line is checked. Attach safety plan.

c. **Unsafe.** If the worker determined that one or more children could not be safely kept in the home even after considering a complete range of interventions, this line is checked. It is possible that the worker will determine that interventions make it possible for one child to remain in the home while another must be removed. Check this line if ANY child is placed. Ensure that the court report or order is in the hard copy record.

Accurate completion of the safety assessment adheres to the following internal logic:

If no safety factors are checked, there should be no interventions checked, and the only possible safety decision is **1. Safe, no intervention required.**

If one or more safety factors are checked, there must be at least one intervention checked, and the only possible safety decisions are **2. Conditionally safe, requiring intervention** or **3. Unsafe, requiring placement.**

If one or more interventions are checked AND placement is not checked as an intervention, the safety decision that should be checked is **2. Conditionally safe, requiring intervention.** Placement should not be checked as an intervention if other interventions are checked.

If placement is checked as an intervention, the safety decision must be **3. Unsafe, requiring placement.**

4.16 Appendix E: Initial Screening Assessment

Domestic Violence

Ask the client:

Is there a person in your life who might do any of the following:

1. Physically hurt you or threaten to hurt you or someone else close to you?

˜ Yes ˜ No ˜ Don't know

2. Check up on you or follow you?

˜ Yes ˜ No ˜ Don't know

3. Make all or most decisions for you?

˜ Yes ˜ No ˜ Don't know

4. Withhold money for food, clothing, or other needs?

˜ Yes ˜ No ˜ Don't know

5. Tell you who you can see or talk to?

˜ Yes ˜ No ˜ Don't know

6. Tell you where you can go?

˜ Yes ˜ No ˜ Don't know

If the client answers YES to any of these questions, a referral for a more complete assessment or for domestic violence services is indicated.

AOD SCREENING TOOL

(CAGE Instrument adapted to include Drugs – CAGEAID)

Ask:

- Have you ever felt you ought to cut down on your drinking or drug use?
- Have people annoyed you by criticizing your drinking or drug use?
- Have you felt bad or guilty about your drinking or drug use?
- Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover or to get the day started?

A “yes” answer to any of these questions indicates the probable need to refer for a more in-depth evaluation of drug and/or alcohol use.

4.17 Appendix F: Safety Plan

Agency: _____ Date: _____

Parent(s)/Caretaker(s): _____ Child(ren): _____

Initial Report, Related to Child Safety: _____

_____

_____

_____

Summary of safety factors identified and any protective factors that address the safety concerns:

_____

_____

_____

_____

_____

_____

Immediate needs identified by family and/or service worker: _____

_____

_____

_____

Caretaker(s) actions/referrals/safety plan: _____

_____

_____

_____

_____

_____

Service worker plans/actions:

_____

_____

_____

_____

Caretaker(s): _____ Date: _____

Service Worker: _____ Date: _____

Others: _____

032-02-033/1 (4/04)

4.17.1 Safety Plan instructions

How to use this form: This form is intended to be used with the family to determine and document what is needed to keep a child or all the children in the home safe for a limited amount of time. It is designed to be used in conjunction with the Safety Assessment Checklist, and is required to be completed if the Safety Decision is Conditionally Safe or Unsafe. (A court order can substitute for the Plan when the child is deemed Unsafe and court intervention is needed.)

1. The first Date should correspond to the Date on the Safety Assessment Checklist.

2. The Child Safety Concerns will usually briefly state the allegations in the complaint. However, if the CPS worker immediately identifies other concerns upon first meaningful contact, these should be included here.

3. Initial Assessment of Safety provides space to briefly note the primary safety concerns and any balancing protective factors identified on the Safety Assessment Checklist.

4. Immediate Needs should relate to needs that must be met in order to keep the children safe, not generic needs that may be expressed by family members and met through a prevention case opening or referral.

5. Steps to Be Taken by Caretaker again refers to steps or actions needed to keep the children safe, not a full-blown service plan that may address a multitude of needs and services.

6. Service worker Plans/Actions should list any actions the worker has agreed to take to keep the child(ren) safe. This is also the place to note any consequences the worker must take if the Caretaker does not follow through on agreed upon steps listed in # 5.

7. Signature lines are provided so that this form can be an agreement for short-term actions to be taken by all parties to keep the child(ren) safe.

A copy of the form shall be provided to the caretaker and any other parties to the plan. (It has an original and two (2) copies and can be photocopied.)

4.18 Appendix G: Family Service Agreement

Family Name: **Case 3:**
Service Worker: **Locality:**
Date Initiated: **Revised:** **Revised:**

Check (√) Primary Goal:

_ Prevent Abuse/Neglect _ Preserve/Strengthen Family
_ Family Reunification _ Child Safety/Protect Child
_ Other Date Goal to Be Achieved_____

IMMEDIATE NEEDS:

1.

2.

3.

LONG-TERM NEEDS:

1.

2.

3.

Services to be Obtained or Provided to Meet these Needs				
Who	**What**	**When**	**Where**	**Why**

Services to be Obtained or Provided to Meet these Needs				
Who	**What**	**When**	**Where**	**Why**

Comments or other information:

This **agreement will be reviewed on** _____ (date) or sooner if requested earlier by local department, family, or service provider.

This is not a legally binding document. However, it is:
_ A statement of mutually identified child and family service needs, agreed to by the family and the local department of social services and others.

And/Or

_ Notice to the family of child safety concerns and needed actions/services to protect the child(ren), prevent abuse or neglect, and/or strengthen the family.

_____
Parent/Caretaker Date

_____
Parent/Caretaker Date

_____
Service Worker Date

_____
Service Provider Date

_____
Other Resource Date

4.18.1 Family Service Agreement instructions

How to use this form: This form is required when services are to be provided as a result of a CPS Family Assessment. All parties to the plan should sign and date the agreement and receive a copy of the agreement. This form may be used as a Service Application Form.

Family Name:	Complete name of head of household.
CASE NUMBER:	OASIS OR LOCALLY ASSIGNED NUMBER
Service Worker:	Name of the assigned service worker
Locality:	Name of the LDSS
Check Primary Goal:	Check one goal and write in the anticipated date of achievement.

Immediate and Long-Term Needs: Although the worker and the family may identify many needs, the worker must assist the family to prioritize so that the family is not overwhelmed. Addressing no more than three short-term and three long-term needs at any given time will enhance the likelihood of a successful outcome.

Immediate needs will describe actions or services needed to keep the child(ren) safe or to address an issue the family has identified as very important to them.

Long-term needs will describe actions or services that cannot be accomplished quickly but are essential to address underlying causative factors, such as drug treatment.

Who: Write in the name or initials of the person(s) who is to participate in the service or action

What: Describe the service or name the service provider

When: Note the date the service is to begin

Where: Either write “in home” or give the location where the service will be delivered

Why: Describe the expected change or result related to this service

Comments or other information: May use this space for any pertinent information needed to expedite the plan, such as transportation arrangements, who to call to set up the service, etc.

Agreement review date: Note the date that the worker and family will evaluate the plan - should be no later than three months from the date the plan is initiated.

Check statement when all parties agree to the plan. Check notice when parties cannot agree but a plan is required to protect the child.

4.19 Appendix H: CPS Risk Assessment Tool

VIRGINIA DEPARTMENT OF SOCIAL SERVICES r: 07/11
FAMILY RISK ASSESSMENT

OASIS Referral Name: _____ **Case #:** _____ **Date:** _____/_____/_____

County Name: _____ **Worker Name:** _____ **Worker ID#:** _____

Primary Caretaker: _____ **Secondary Caretaker:** _____

	Total	Neglect	Abuse
Prior Assessments:	_____	_____	_____
Prior Investigations:	_____	_____	_____
Prior Founded Investigations:	_____	_____	_____

NEGLECT — Score

N1. Current complaint is for physical or medical neglect
- a. No 0
- b. Yes ..... 2 _____

N2. Prior investigations/assessments (assign highest score that applies)
- a. None ..... -1
- b. One or more, abuse only 1
- c. One or two for neglect 2
- d. Three or more for neglect ..... 3 _____

N3. Household has previously received ongoing services or foster care as a result of CA/N (voluntary/court-ordered)
- a. No 0
- b. Yes ..... 3 _____

N4. Number of children involved in the CA/N incident (number = _____)
- a. One, two, or three 0
- b. Four or more ..... 2 _____

N5. Age of youngest child in the home (age = _)
- a. 2 or older 0
- b. Under 2 ..... 1 _____

N6. Primary caretaker provides physical care inconsistent with child needs
- a. No 0
- b. Yes ..... 1 _____

N7. Primary caretaker has a history of abuse or neglect as a child
- a. No 0
- b. Yes ..... 2 _____

N8. Primary caretaker has/had a mental health problem
- a. None/not applicable 0
- b. One or more apply ..... 1 _____
  - ____ During the last 12 months AND/OR
  - ____ At any other time prior to that

N9. Primary caretaker has/had a drug or alcohol problem
- a. None/not applicable 0
- b. One or more apply ..... 2 _____
  - ____ During the last 12 months AND/OR
  - ____ At any other time prior to that

N10. Primary caretaker has criminal arrest history as adult or juvenile
- a. No 0
- b. Yes ..... 1 _____

N11. Characteristics of children in household
- a. Not applicable 0
- b. One or more apply ..... 1 _____
  - ____ Developmental or physical disability
  - ____ Medically fragile/failure to thrive
  - ____ Positive toxicology screen at birth

N12. Current housing
- a. Not applicable 0
- b. One or more apply ..... 1 _____
  - ____ Physically unsafe AND/OR
  - ____ Family homeless

TOTAL NEGLECT RISK SCORE _____

ABUSE — Score

A1. Current allegation of physical abuse is founded or supported
- a. No 0
- b. Yes ..... 1 _____

A2. Number of prior abuse investigations/assessments
- a. None 0
- b. One 1
- c. Two or more ..... 2 _____

A3. Household has previously received ongoing services or foster care as a result of CA/N (voluntary/court-ordered)
- a. No 0
- b. Yes ..... 2 _____

A4. Prior injury to a child resulting from CA/N
- a. No 0
- b. Yes ..... 2 _____

A5. Primary caretaker's assessment of incident
- a. Not applicable 0
- b. One or more apply ..... 1 _____
  - ____ Blames child AND/OR
  - ____ Justifies maltreatment of a child

A6. Two or more incidents of domestic violence in the household in the past year
- a. No 0
- b. Yes ..... 1 _____

A7. Primary caretaker characteristics
- a. Not applicable 0
- b. One or more apply ..... 1 _____
  - ____ Provides insufficient emotional/psychological support
  - ____ Employs excessive/inappropriate discipline
  - ____ Domineering parent

A8. Primary caretaker has a history of abuse or neglect as a child
- a. No 0
- b. Yes ..... 1 _____

A9. One or more caretaker(s) has/had an alcohol and/or drug problem
- a. No 0
- b. Yes (check all applicable) ..... 1 _____
  - During the last 12 months:
    - [ ] Primary caretaker [ ] Secondary caretaker
  - At any other time prior to that:
    - [ ] Primary caretaker [ ] Secondary caretaker

A10. Primary caretaker has criminal arrest history as adult or juvenile
- a. No 0
- b. Yes ..... 1 _____

A11. Characteristics of children in household
- a. Not applicable 0
- b. One or more apply ..... 1 _____
  - ____ Delinquency history
  - ____ Developmental disability
  - ____ Mental health/behavioral problem

TOTAL ABUSE RISK SCORE _____

SCORED RISK LEVEL. Assign the family's scored risk level based on the highest score on either the neglect or abuse instrument, using the following chart:

Neglect Score	Abuse Score	Scored Risk Level
_____ -1–0	_____ 0–1	_____ Low
_____ 1–3	_____ 2–4	_____ Moderate
_____ 4–8	_____ 5–8	_____ High
_____ 9 +	_____ 9 +	_____ Very High

POLICY OVERRIDES. Circle yes if a condition shown below is applicable in this case. If any condition is applicable, override final risk level to very high.

Yes No 1. Sexual abuse case AND the perpetrator is likely to have access to the child victim.
Yes No 2. Non-accidental injury to a child under age 3.
Yes No 3. Severe non-accidental injury.
Yes No 4. Parent/caretaker action or inaction resulted in death of a child due to abuse or neglect (previous or current).

DISCRETIONARY OVERRIDE. If a discretionary override is made, circle yes, circle override risk level, and indicate reason. Risk level may be overridden one level higher.

Yes No 5. If yes, override risk level (circle one): Low Moderate High Very High

Discretionary override reason: _____

Supervisor's review/approval of discretionary override: _____ Date: _____/_____/_

FINAL RISK LEVEL (circle final level assigned): Low Moderate High Very High

4.19.1 SDM® Family Risk Assessment definitions

The risk assessment is composed of two indices, the neglect index and the abuse index. Both indices are completed for each investigation/assessment. Only one household can be assessed on a risk assessment. If two households are involved in the alleged incident(s), separate risk assessments should be completed for each household.

The household includes all persons who have significant in-home contact with the child, including those who have a familial or intimate relationship with any person in the home.

The primary caretaker is the adult living in the household where the allegation occurs who assumes the most responsibility for child care. When two adult caretakers are present and the service worker is in doubt as to which one assumes the most child care responsibility, the adult with legal responsibility for the child involved in the incident should be selected as the primary caretaker. For example, when a mother and her boyfriend reside in the same household and appear to equally share caretaking responsibilities for the child, the mother is selected. If this does not resolve the question, the legally responsible adult who was a perpetrator or alleged perpetrator should be selected. For example, when a mother and a father reside in the same household and appear to equally share caretaking responsibilities for the child and the mother is the perpetrator (or the alleged perpetrator), the mother is selected. In circumstances where both parents are in the household, equally sharing caretaking responsibilities, and both have been identified as perpetrators or alleged perpetrators, the parent demonstrating the more severe behavior is selected. Only one primary caretaker can be identified.

The secondary caretaker is defined as an adult living in the household who has routine responsibility for child care, but less responsibility than the primary caretaker. A partner may be a secondary caretaker even though he or she has minimal responsibility for care of the child.

Note: **Scoring of Mental Abuse/Neglect**. Mental abuse/neglect was a relatively rare occurrence in the risk research. As a result, it did not show up as a risk factor in the same way that neglect or physical abuse did and is not scored on the risk assessment. If the only allegation is mental abuse/neglect, N1 and A1 should be scored “0.” Note that if such cases turn out low or moderate risk as a result, and documentation supports that the nature of the referral in and of itself elevates the risk level, the case still can be opened for services.

Note: **Scoring of Sexual Abuse**. For the same reason above, if the only allegation is sexual abuse, A1 should be scored “0.” Note that if such cases turn out low or

moderate risk as a result, and documentation supports that the nature of the referral in and of itself elevates the risk level, the case still can be opened for services.

Note: **Scoring of Substance Exposed Infant**. If the current allegation is for substance-exposed infant, that should be scored under N1, not under abuse.

4.19.1.1 Neglect

N1. Current complaint is for physical or medical neglect

Note: If the only allegation is mental abuse/neglect, N1 and A1 should be scored "0." If the current allegation is for substance exposed infant that should be scored under N1, not under abuse.

Score 2 if the current complaint is for neglect. **Neglect** occurs when a parent or other person responsible for child's care neglects or refuses to provide care necessary for child's health; when a child is without parental care or guardianship, caused by the unreasonable absence or the mental or physical incapacity of the child's parent, guardian, legal custodian, or other person standing in loco parentis; when parents or other persons responsible for child's care abandon such child.

This includes referred allegations as well as allegations made during the course of the investigation/assessment.

For alternative caretaker households, answer "no."

N2. Prior investigations/assessments

Note: When counting prior investigations/assessments, it does not matter whether the prior investigations were founded or not, or whether the prior assessments resulted in a determination that services were needed. Include all persons who have significant in-home contact with the child when considering priors. If the family does not self-report priors, but the worker is certain that there have been priors that are not in OASIS, that should be counted.

However, do not count screened-out referrals.

a. Score -1 if there were no investigations/assessments prior to the current investigation/assessment.

b. Score 1 if there were one or more investigations/assessments for any type of <u>abuse</u> prior to the current investigation/assessment. Abuse includes physical, emotional, or sexual abuse/sexual exploitation.

c. Score 2 if there were one or two investigations/assessments for any type of neglect (alone or in combination with an abuse investigation / assessment) prior to the current investigation/assessment.

d. Score 3 if there were three or more investigations / assessments for any type of neglect (alone or in combination with an abuse investigation / assessment) prior to the current investigation/assessment.

Where possible, history from other county or state jurisdictions should be checked. Exclude investigations/assessments of out-of-home perpetrators (e.g., daycare) unless one or more caretakers failed to protect.

N3. Household has previously received ongoing services or foster care as a result of CA/N (voluntary/court-ordered)

Score 3 if household has previously received child welfare services or is currently receiving services as a result of child abuse or neglect. Case may have opened as a result of a referral or court order. Service history includes voluntary or court-ordered family services, but does not include delinquency or CHINS services.

N4. Number of children involved in the CA/N incident

Enter the total number of children involved in the CA/N incident who live in this home. Score the appropriate amount given the number of children under 18 years of age for whom abuse or neglect was alleged in the current investigation/assessment.

N5. Age of youngest child in the home

Enter the age, in years, of the youngest child living in the home. Enter 0 for children under age 1. Score the appropriate amount given the current age of the youngest child presently in the household where the maltreatment incident reportedly occurred. If a child is removed as a result of the current investigation/assessment, count the child as residing in the home.

N6. Primary caretaker provides physical care inconsistent with child needs

Score 1 if physical care of child (age-appropriate feeding, clothing, shelter, hygiene, and medical care of child) threatens the child's well-being or results in harm to child. Examples include, but are not limited to the following:

- Repeated failure to obtain standard immunizations (while this does not constitute neglect, research identified this as risk factor);
- Failure to obtain medical care for severe or chronic illness;

- Repeated failure to provide child with clothing appropriate to the weather;
- Persistent rat or roach infestations;
- Inadequate or inoperative plumbing or heating;
- Poisonous substance or dangerous objects lying within reach of small child;
- Child is wearing filthy clothes for extended periods of time; or
- Child is not being bathed on a regular basis, resulting in dirt caked on skin and hair and a strong odor.

N7. Primary caretaker has a history of abuse or neglect as a child

Score 2 if credible statements by the primary caretaker or others, or state records of past allegations, indicate that the primary caretaker was maltreated as a child (maltreatment includes neglect or physical, sexual, or other abuse).

N8. Primary caretaker has/had a mental health problem

a. Score 0 if primary caretaker has no current or past mental health problem.

b. Score 1 if credible and/or verifiable statements by the primary caretaker or others indicate that the primary caretaker:

- Has been diagnosed as having a significant mental health disorder as indicated by a Diagnostic and Statistical Manual (DSM) condition (excluding diagnosis of mental retardation) determined by a mental health clinician;
- Has had repeated referrals for mental health/psychological evaluations; or
- Was recommended for treatment/hospitalization or treated/hospitalized for emotional problems.

Indicate whether the mental health problem was/is present DURING the past 12 months AND/OR was present at any time prior to 12 months.

N9. Primary caretaker has/had a drug or alcohol problem

a. Score 0 if the primary caretaker does not have and never has had a drug or alcohol problem.

b. Score 2 if the primary caretaker has a past or current alcohol/drug abuse problem that interferes with his/her or the family's functioning. Such interference is evidenced by the following:

- Substance use that affects or affected the following:
  - Employment,
  - Criminal involvement,
  - Marital or family relationships, or
  - Ability to provide protection, supervision, and care for the child.
- An arrest in the past two years for driving under the influence or refusing breathalyzer testing.
- Self-report of a problem.
- Treatment received currently or in the past.
- Multiple positive urine samples.
- Health/medical problems resulting from substance use.
- Child was diagnosed with fetal alcohol syndrome or exposure (FAS or FAE) or child had a positive toxicology screen at birth <u>and</u> primary caretaker was birthing parent.

Legal, non-abusive prescription drug use should not be scored.

Indicate whether the drug or alcohol problem was/is present DURING the past 12 months AND/OR was present at any time prior to 12 months.

N10. Primary caretaker has criminal arrest history as adult or juvenile

Indicate whether the primary caretaker has been arrested or convicted prior to the current complaint as either an adult or a juvenile. This includes DUI but excludes all other traffic offenses. Information may be located in the case narrative material, reports from other agencies, etc. Also, review any police reports in the file for this information.

N11. Characteristics of children in household

a. Score 0 if no child in the household exhibits characteristics listed below.

b. Score 1 if any child in the household is/has any or all of the following:

- Developmental or physical disability, including a formal diagnosis of any of the following: mental retardation, learning disability (as indicated by school records), other developmental problem, or significant physical handicap. (**Note**: Do not include ADD/ADHD here.)

- Medically fragile, defined as having a long-term (six months or more) physical condition requiring medical intervention or diagnosed as failure to thrive.

- Positive toxicology report for alcohol or another drug at birth. (**Note**: This should be scored if the child tested positive, or a physician's diagnosis is that the child has been exposed to substances.)

N12. Current housing

a. Score 0 if the family has housing that is physically safe.

b. Score 1 if any of the following apply:

- The family has housing, but the current housing situation is physically unsafe such that it does not meet the health or safety needs of the child (for example, exposed wiring, inoperable heat or plumbing, roach/rat infestations, human/animal waste on floors, rotting food).

- The family is homeless or is about to be evicted at the time the investigation/assessment began. Consider as "homeless" people who are living in a shelter and those living on a short-term basis with relatives or friends.

4.19.1.2 Abuse

A1. Current allegation of physical abuse is founded or supported

Score 1 if the physical abuse allegation was investigated and founded OR was assessed and results indicate that physical abuse occurred. (This includes exposure to sale or manufacture of certain controlled substances.) If the only allegation is sexual abuse, A1 should be scored "0." If the only allegation is mental abuse/neglect, N1 and A1 should be scored "0." If the current allegation is for substance exposed infant that should be scored under N1, not under abuse.

For alternative caretaker households, answer "no."

A2. Number of prior abuse investigations/assessments

Score the appropriate amount given the count of all investigations / assessments, founded or not, for any type of abuse (physical, mental, or sexual

abuse/sexual exploitation) prior to the complaint resulting in the current investigation/assessment. Where possible, abuse history from other county or state jurisdictions should be checked. Exclude screened-out referrals and investigations/assessments of out-of-home perpetrators (e.g., daycare) unless one or more caretakers failed to protect.

A3. Household has previously received ongoing services or foster care as a result of CA/N (voluntary/court-ordered)

Score 2 if household has previously received child welfare services or is currently receiving services as a result of child abuse or neglect. Case may have opened as a result of a referral or court order. Service history includes voluntary or court-ordered family services, but does not include delinquency or CHINS services.

A4. Prior injury to a child resulting from CA/N

Score 2 if a child sustained an injury resulting from abuse and/or neglect (based on credible information of prior injury regardless of whether there was a referral) prior to the complaint that resulted in the current investigation / assessment. Injury sustained as a result of abuse or neglect may range from bruises, cuts, and welts to an injury that requires medical treatment or hospitalization, such as a bone fracture or burn.

A5. Primary caretaker's assessment of incident

a. Score 0 if none of the characteristics below is applicable.

b. Score 1 if any of the following apply:

- The primary caretaker blames child for incident. Blaming refers to caretaker's statement that maltreatment incident occurred because of child's action or inaction (for example, claiming that the child seduced him/her, or child deserved beating because he/she misbehaved).

- The primary caretaker justifies maltreatment of child. Justifying refers to caretaker's statement that his/her action or inaction, which resulted in harm to the child, was appropriate (for example, claiming that this form of discipline was how he/she was raised, so it is all right).

A6. Two or more incidents of domestic violence in the household in the past year

Score 1 if in the previous year there have been two or more physical assaults or multiple periods of intimidation/threats/harassment between caretakers or

between a caretaker and another adult in the home. Count police reports and credible self-reports by parents, other family members, etc.

A7. Primary caretaker characteristics

a. Score 0 if the primary caretaker does not exhibit characteristics listed below.

b. Score 1 if any of the following apply:

- The primary caretaker provides insufficient emotional/psychological support to the child, such as persistently berating/belittling/demeaning child or depriving child of affection or emotional support.
- The primary caretaker's disciplinary practices caused or threatened harm to the child because they were excessively harsh physically or emotionally and/or inappropriate to the child's age or development. Examples include but are not limited to the following:
  - Locking child in closet or basement;
  - Holding child's hand over fire;
  - Hitting child with instruments; or
  - Depriving young child of physical and/or social activity for extended periods.
- The primary caretaker is domineering, indicated by controlling, abusive, overly restrictive or unfair behavior, or overreactive rules.

A8. Primary caretaker has a history of abuse or neglect as a child

Score 1 if credible statements by the primary caretaker or others indicate that the primary caretaker was maltreated as a child (maltreatment includes neglect or physical, sexual, or other abuse).

A9. One or more caretaker(s) has/had an alcohol and/or drug problem

a. Score 0 if no caretaker has or has ever had an alcohol or drug problem.

b. Score 1 if any caretaker has a past or current alcohol/drug abuse problem that interferes with his/her or the family's functioning. Such interference is evidenced by the following:

- Substance use that affects or affected the following:

- Employment.
- Criminal involvement.
- Marital or family relationships.
- Ability to provide protection, supervision, and care for the child.

- An arrest in the past two years for driving under the influence or refusing breathalyzer testing.
- Self-report of a problem.
- Received or is receiving treatment.
- Multiple positive urine samples.
- Health/medical problems resulting from substance use.
- Child was diagnosed with FAS or FAE or child had a positive toxicology screen at birth and secondary caretaker was birthing parent.

Legal, non-abusive prescription drug use should not be scored.

Indicate whether the primary AND/OR secondary caretaker's alcohol or drug problem is present at this time or DURING the past 12 months.

Indicate whether the primary AND/OR secondary caretaker's alcohol or drug problem was present at some time prior to 12 months. BOTH timeframes may be marked if applicable.

A10. Primary caretaker has criminal arrest history as adult or juvenile

Indicate whether the primary caretaker has been arrested or convicted prior to the current complaint as either an adult or a juvenile. This includes DUI but excludes all other traffic offenses. Information may be located in the case narrative material, reports from other agencies, etc. Also review any police reports in the file for this information.

A11. Characteristics of children in household

a. Score 0 if no child in the household exhibits characteristics listed below.

b. Score 1 if any child in the household:

- Has been referred to juvenile court for delinquent or status offense behavior. Status offenses not brought to court attention but that create

stress within the household should also be scored, such as children who run away or are habitually truant.

- Is developmentally disabled, including mental retardation, learning disability, or other developmental problem.
- Has mental health or behavioral problems not related to a physical or developmental disability (includes ADHD/ADD). This could be indicated by the following:
  - A DSM diagnosis;
  - Receiving mental health treatment;
  - Attendance in a special classroom because of behavioral problems; or
  - Currently taking psychoactive medication.

4.19.2 Family Risk Assessment Tool procedures

Risk assessment identifies families who have low, moderate, high, or very high probabilities of future abuse or neglect. By completing the risk assessment, the worker obtains an objective appraisal of the likelihood that a family will maltreat their children in the next 18 to 24 months. The difference between risk levels is substantial. High risk families have significantly higher rates of subsequent referral and substantiation than low risk families and are more often involved in serious abuse or neglect incidents.

When risk is clearly defined and objectively quantified, the choice between serving one family or another is simplified: agency resources are targeted to higher risk families because of the greater potential to reduce subsequent maltreatment.

The risk assessment is based on research on cases with substantiated abuse or neglect that examined the relationships between family characteristics and the outcomes of subsequent substantiated abuse and neglect. The assessment does not predict recurrence, but simply assesses whether a family is more or less likely to have another incident without intervention by the agency.

Which Cases: All investigations and assessments except out-of-family caretaker.

Who: The CPS worker who is conducting the investigation/assessment.

When: After the safety assessment has been completed and the worker has reached a conclusion regarding the allegation AND prior to the referral being closed or promoted to a case. This is no later

than 45 days after the complaint was received, or within 60 days if an extension was granted.

Decisions: The risk assessment identifies the level of risk of future maltreatment.

The risk level guides the decision whether or not to open a case.

Risk-based CPS Case Open/Close Guide	
Risk Level	**Indicated Decision**
Low	Close
Moderate	Open to CPS or close
High	Open to CPS
Very High	Open to CPS

Appropriate Completion: The risk assessment is completed based on conditions that exist at the time the incident is reported and investigated as well as the prior history of the family. Only one household can be assessed on the risk assessment. Choose the household in which the CA/N incident is alleged. If more than one household is involved, there should be a referral on each household and one risk assessment completed for each referral.

Scoring Individual Items: A score for each assessment item is derived from the worker's observation of the characteristics it describes. Some characteristics are objective (such as prior CA/N history or the age of the child). Others require the worker to use discretionary judgment based on his or her assessment of the family. Sources of information used to determine the worker's endorsement of an item may include statements by the child, caretaker, or collateral persons; worker observations; reports; or other reliable sources.

The worker should refer to the tool's definitions to determine his/her selection for each item.

After all index items are scored, the worker totals the score and indicates the corresponding risk level for each index. Next, the scored risk level (which is the higher of the abuse or neglect indices) is entered.

Policy Overrides: After completing the risk assessment, the worker determines whether any of the policy override reasons exist. Policy overrides reflect incident seriousness and/or child vulnerability concerns, and have been determined by the agency to warrant a risk level designation of very high regardless of the risk level indicated by the assessment tool. Policy overrides require supervisor approval.

Note: Circle yes or no as appropriate for each policy override.

1. Sexual abuse case AND the perpetrator is likely to have access to the child victim.
2. Non-accidental injury to a child under age 3.
3. Severe non-accidental injury (e.g., brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocations, sprains, internal injury, poisoning, burns, scalds, severe cuts, or any other physical injury that seriously impairs the health or well-being of the child and requires medical treatment).
4. Parent/caretaker action or inaction resulted in death of a child due to abuse or neglect (previous or current).

Discretionary Overrides: A discretionary override is applied by the worker to increase the risk level in any case in which the service worker believes that the risk level set by the assessment is too low. This may occur when the worker is aware of conditions affecting risk that are not captured within the items on the risk assessment. Discretionary overrides may increase the risk level by one unit (for example, from low to medium, or medium to high, but NOT from low to high).[11] Discretionary overrides require supervisor approval.

After completing the override section, indicate the final risk level, which is the highest risk level obtained.

[11] At the time of risk reassessment, discretionary overrides may increase *or decrease* risk by one level. However, at the time of initial assessment, risk level may only be increased.

4.20 Appendix I: Individuals with Disabilities Education Act

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RECEIVED
APR 30 2010
OFFICE OF THE COMMISSIONER
DEPT. OF SOCIAL SERVICES

COMMONWEALTH of VIRGINIA

DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

JAMES W. STEWART, III
COMMISSIONER

Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 786-3921
Voice/TDD (804) 371-8977
www.dbhds.virginia.gov

April 21, 2010

Margaret Schultze, Interim Commissioner
Department of Social Services
801 E. Main Street
Richmond, VA 23219-2901

Dear Ms. Schultze:

In 2004, the Individuals with Disabilities Education Improvement Act reauthorized and made changes to the early intervention program for infants and toddlers with disabilities and their families under Part C of the Individuals with Disabilities Education Act (IDEA). In order to address the 2004 changes to Part C and accurately reflect the current Part C system in the Commonwealth, it is necessary to revise Virginia's Memorandum of Agreement Among the Agencies Involved in the Implementation of Part H of the Individuals with Disabilities Education Act (IDEA) to Meet Full Implementation Requirements, which was signed in September 1996.

Section 640 of the 2004 statute reauthorizing Part C provides stronger and more specific requirements associated with the State interagency agreement than did previous legislation. States are required to have an interagency agreement or other mechanism for interagency coordination in effect between each public agency and the designated lead agency, the Department of Behavioral Health and Development Services (DBHDS) in order to ensure:

- The provision of, and financial responsibility for, services provided under Part C; and
- Such services are consistent with the requirements for a statewide system under Part C and statewide assurances, including provision of such services during pendency of any dispute.

The interagency agreement must include all additional components necessary to ensure meaningful cooperation and coordination and must be consistent with the terms and conditions of the State's agreement for Part B of IDEA. The revised agreements for Part C will be submitted to the U.S. Department of Education along with Virginia's annual Part C Application due May 10, 2010.

If you have questions please feel free to contact Mary Ann Discenza at maryann.discenza@dbhds.virginia.gov or at 804-371-6592. I appreciate your continued commitment to Virginia's Part C early intervention system.

Sincerely,

James W. Stewart, III
Commissioner

Copy: Frank L. Tetrick, III
Janet S. Lung
Mary Ann Discenza

Virginia Interagency Memorandum of Agreement Among the Agencies Involved in the Implementation of Part C of the Individuals with Disabilities Education Act (IDEA)

Infant & Toddler
Connection of Virginia

Parties to the Agreement:

Department of Behavioral Health and Developmental Services
Department of Education
Department of Health
Department of Medical Assistance Services
Department of Social Services
Department for the Deaf and Hard-of-Hearing
Department for the Blind and Vision Impaired
Virginia Office for Protection and Advocacy
State Corporation Commission – Bureau of Insurance

May 2010

I. PURPOSE

This agreement among the parties, hereinafter referred to as "participating agencies", documents the understandings and commitments of the participating agencies to meet the statutory and regulatory requirements of Part C of the Individuals with Disabilities Education Act (IDEA) and the Virginia statutory requirements related to Part C.

The purpose of this agreement is to ensure collaboration and coordination in the implementation of Virginia's statewide, comprehensive, family-centered system of Part C early intervention supports and services for infants and toddlers with disabilities and their families. It is the intent of this agreement to ensure optimal use of resources and prevent duplication of effort by detailing each participating agency's commitment and financial responsibility related to Part C systems components (e.g., public awareness, child find, data collection, training) and provision of Part C early intervention supports and services. This agreement replaces the agreement signed in 1996.

II. PARTIES TO AGREEMENT

The parties to this agreement are the participating agencies set forth in Virginia Code § 2.2-5300.

III. AUTHORITY

Virginia Code §§ 2.2–5303

IV. FUNDAMENTAL PRINCIPLES

The participating agencies shall coordinate and implement a comprehensive system of early intervention supports and services that shall be:

A. Family-centered
    1. Parents/caregivers shall be the primary agents of change in their child's development.
    2. Families identify outcomes that are important to them and how supports and services can fit into the family's life and build effectively on the resources and supports already in place.
    3. The focus of supports and services shall be on increasing the child's participation in family and community activities identified by the family.
    4. Language and cultural differences shall be respected and appropriately addressed.

B. Accessible
    1. All eligible infants, toddlers and their families shall be identified and referred to the Part C early intervention system as soon as a delay or disability is suspected.
    2. Supports and services shall begin in a timely manner.
    3. Ability to pay shall not be a barrier to receiving supports and services.

C. Community-based
    1. Supports and services shall be individualized and provided within the context of and integrated into the everyday routines, activities and environments of each child and family.
    2. Children with disabilities are children first and to the extent possible shall be enabled to participate in the full range of activities in integrated settings with their typically developing peers.

D. Coordinated
    1. Interagency coordination shall ensure the responsible use of public money.
    2. Service coordination shall ensure that children and families receive necessary supports and services and reduce duplication of effort.

E. Effective
    1. Family involvement and support is a critical component of effective services for children.

2. Supports and services shall reflect evidence-based practice.
3. Outcomes shall be measured and monitored to determine the effectiveness of early intervention supports and services in making a positive impact on children and families.
4. System improvement shall be ongoing and based on timely and accurate data
5. Stakeholders shall have access to state and local performance data in accordance with applicable federal and state confidentiality laws.

V. DEFINITION OF TARGET POPULATION

Part C early intervention supports and services shall be available to all eligible infants and toddlers with disabilities and their families, including Indian infants and toddlers with disabilities and their families residing on a reservation geographically located in Virginia, infants and toddlers with disabilities who are homeless children and their families, and infants and toddlers with disabilities who are wards of the State. In Virginia, children are eligible if they have (1) a 25% delay in one or more areas of development; (2) atypical development; or (3) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.

VI. MUTUAL AGREEMENTS

All participating state agencies agree to the following:

A. General Agreements

Each participating agency shall:

1. Designate a representative with sufficient authority to engage in policy planning and implementation on behalf of the agency to participate on the Virginia Interagency Coordinating Council (VICC);
2. Provide leadership, direction and coordination, as appropriate, regarding the local planning and provision of services to children and families;
3. Assist local counterparts, if any, in fulfilling their obligations to children and families;
4. Assist in the development of local agreements that will provide guidance to local interagency collaborative efforts;
5. Coordinate the provision of Part C system components and supports and services to avoid duplication of effort;
6. Share and review any contemplated policies related to services for infants, toddlers and their families with the other participating agencies; and
7. Share information about resources that are available within each agency that are mutually helpful. Resources may include material, staff expertise, space, data, training, and/or technology.

B. Financial Agreements

Each participating agency shall:

1. Jointly identify and coordinate use of all available public and private resources to ensure availability of supports and services to all eligible children and their families and to ensure Part C funds are used as payor of last resort;
2. Provide the State Lead Agency annually with expenditure and budget information as part of the annual assessment of State Part C expenditures inclusive of Medicaid and for calculation of maintenance of effort;
3. Adhere to Part C's maintenance of effort requirements within its agency's financial expenditures, in addition to the State's aggregate expenditures;
4. Assure a clear audit trail for all Part C income and expenditures as required by Federal law;
5. Ensure that State and Federal Part C funds are not used for children past their third birthday;
6. Abide by the Part C requirement that the following Part C system functions and services are provided at no cost to families:
    a. Child find;

   b. Evaluation for eligibility determination and assessment;
   c. Service coordination; and
   d. Administrative and coordinative activities related to the development, review and evaluation of Individualized Family Service Plans (IFSPs) and implementation of procedural safeguards;
7. Follow the Family Cost Participation procedures, as identified in the *Infant & Toddler Connection of Virginia Practice Manual*, when providing Part C supports and services to ensure that the inability of the parents of an eligible child to pay for services will not result in the denial of Part C early intervention services to the child or the child's family; and
8. Assist in the development of joint agency budget requests when appropriate.

C. Service Delivery Agreements

Each participating agency shall:

1. Disseminate Part C public awareness materials, including, but not limited to, posters and brochures, during conferences, trainings, and other contacts involving the general public or professionals who have contact with and/or coordinate the medical or developmental care of young children and families or pregnant women;
2. Participate in child find activities designed to locate and identify children who may be eligible for Part C supports and services;
3. Refer and/or require local counterparts to refer all potentially eligible infants, toddlers and their families to the Infant & Toddler Connection of Virginia through the appropriate local single point of entry as soon as possible after identifying the child as potentially eligible;
4. Follow all Part C procedural safeguards, including confidentiality requirements, as identified in Virginia's Part C Policies and Procedures, during eligibility determination, assessment, individualized family service plan (IFSP) development, and the provision of supports and services;
5. Provide information to parents about ways to connect to family support resources, including related agencies, services, training, support groups, advocacy organizations and family leadership opportunities;
6. Support culturally diverse approaches to service delivery that reflect sensitivity to the different cultures involved in the Infant & Toddler Connection of Virginia system;
7. Make efforts to enhance the capacity of the participating agencies and their local providers to identify, assess, and meet the needs of under represented groups, including low income and minority populations, homeless children and families, wards of Virginia, and Indian children and families living on reservations;
8. Share information about eligible children and their families, to the extent consistent with State and Federal confidentiality requirements, including the requirements of the Health Information Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA), in order to get accurate and unduplicated counts to meet Federal reporting requirements and to facilitate the effective and efficient delivery of services; and
9. For participating agencies that provide Part C services either directly or through local counterparts:
   a. Ensure, to the maximum extent appropriate for each child, all early intervention services are provided in natural environments, which mean settings that are natural or normal for the child's age peers who have no disabilities. Early intervention services can occur in a setting other than a natural environment only if early intervention cannot be achieved satisfactorily for the infant or toddler in a natural environment and if the child's IFSP includes a (child-based) reason why the service can not be provided in a natural environment.
   b. Ensure the timely start of services, within 30 calendar days of the date the family signs the Individualized Family Service Plan (IFSP), unless the IFSP

team determines that a later start date is necessary to meet the child's or family's needs.

D. Personnel Development, Training and Technical Assistance Agreements
Each participating agency shall:

1. Collaborate in planning, developing, and conducting training and providing technical assistance for service providers and families. Coordination of efforts will include, but not be limited to:
   - **a.** Sharing needs assessments;
   - **b.** Offering cooperatively sponsored or jointly attended training activities;
   - **c.** Blending funding streams for training when applicable policies allow;
   - **d.** Posting training events on the "Early Childhood Meeting Place;" and
   - **e.** Collaborating on scheduling, evaluation of training, and disseminating information about planned training;
2. Ensure trainings offered reflect culturally competent practices and promote family-centered practices; and
3. Encourage parental involvement in the planning and implementation of training, including parents as trainers and co-trainers.

E. Monitoring and Supervision Agreements
Each participating agency shall:

1. Participate in monitoring and supervision activities for the Infant & Toddler Connection of Virginia. Activities may include, but are not limited to:
   - a. Analysis of data for the purpose of monitoring, supervision and/or system planning and improvement;
   - b. On-site visits with local systems;
   - c. Fiscal monitoring and verification;
   - d. Desk audits;
2. Support local counterparts in the implementation of corrective action plans and service enhancement plans; and
3. Share results from agency/program monitoring or other quality assurance activities upon request.

VI. TRANSITION AGREEMENT BETWEEN THE DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES AND THE DEPARTMENT OF EDUCATION

In Virginia, children who reach the age of two on or before September 30 of any given year and who meet Part B eligibility requirements as defined in the *Code of Virginia* and in accordance with the *Regulations Governing Special Education Programs for Children with Disabilities in Virginia* are eligible to receive special education and related services through their local school divisions. In order to ensure a smooth and timely transition for children exiting the Infant & Toddler Connection of Virginia:

A. The Department of Behavioral Health and Developmental Services (DBHDS) shall:

1. Require local lead agencies, through the Local Contract for Participation in Part C, to:
   - a. Develop local interagency agreements with local school divisions that specify local roles and responsibilities for participation on the local interagency coordinating council and for accomplishing the transition planning and activities required under Part C and Part B of IDEA;
   - b. Ensure transition is discussed with the family at each IFSP meeting, beginning with the initial IFSP, and that appropriate transition steps and services to support a smooth transition are documented on each child's IFSP;
   - c. Notify the local school division of children residing in the community who are potentially eligible for Part B services by transmitting each child's name,

address, phone number and birth date to the local school division as the child nears the age of eligibility for Part B;

d. Refer children who are potentially eligible for Part B to the local school division, with parent consent, by April 1 or as soon as the parent gives consent, and transfer child-specific information (including eligibility and assessment information and copies of IFSPs) to ensure continuity of services;

e. Coordinate and ensure Part C participation in an individual transition planning conference between the family, the local Part C system and the local school division at least 90 days and no more than 9 months before the child's third birthday or the date on which the child will be eligible under Part B of IDEA. The purpose of the transition conference is to review the child's program options for the period from the third birthday through the remainder of the school year and establish a transition plan in accordance with requirements in Section 637 of the IDEA; and

f. Make reasonable efforts to convene a conference, with the approval of the family, among the local Part C system, the family, and providers of other appropriate services for children who may not be eligible for Part B services;

2. Share data including, but not limited to, the following:
   a. Child outcome data, with parent consent; and
   b. Other data as appropriate to meet reporting needs and improve services; and
3. Work collaboratively with the Department of Education (DOE) towards a common identifier in the Part C and Part B data systems that will facilitate sharing of data and longitudinal tracking and data collection.

B. The Department of Education shall:

1. Require local school divisions to:
   a. Enter into local interagency agreements with the Part C local lead agency to specify local roles and responsibilities for accomplishing the transition planning and activities required under Part C and Part B of IDEA;
   b. Accept notification from the local Part C system of children who are residing in the community who are potentially eligible for Part B services;
   c. Process referrals, including child-specific information from the local Part C system at any time during the calendar year, if the parent consents;
   d. Participate in the individual transition planning conference between the family, the local Part C system and the local school division at least 90 days and no more than 9 months before the child's third birthday or the date on which the child will be eligible under Part B of IDEA;
   e. Review the assessment data transmitted from the Infant & Toddler Connection of Virginia to determine if it is appropriate or sufficient to assist in determining the eligibility of a particular child for special education and related services. The local school division shall utilize this information whenever appropriate to avoid unnecessary reassessment and delays in services;
   f. Invite the Part C service coordinator or other Part C representative to the initial Individualized Education Plan (IEP) meeting if the parent so requests;
   g. Consider the child's IFSP when developing the initial IEP;
   h. Develop an initial IEP specifying the child's program as of his/her third birthday or the earlier date on which the child is eligible to begin Part B services (e.g., the beginning of the school year in which the child is 2 years old by September 30); and
   i. Accept financial responsibility of all special education and related services to an eligible child on the child's third birthday or the earlier date on which the child is eligible to begin Part B services (e.g., the beginning of the school year in which the child is 2 years old by September 30);

2. Share data including, but not limited to, the following:
    a. Child outcome data, with parent consent;
    b. Verified Section 618 child count data on children under three served through Part B to DBHDS in January of each year for reporting to OSEP; and
    c. Other data as appropriate to meet reporting needs and improve services; and
3. Work collaboratively with DBHDS toward a common identifier in the Part C and Part B data systems that will facilitate sharing of data and longitudinal tracking and data collection.

VII. AGENCY-SPECIFIC AGREEMENTS

A. The Department of Behavioral Health and Developmental Services (DBHDS) shall:

1. Fulfill the responsibilities of State Lead Agency by:
    a. Serving as a single line of responsibility for the Infant & Toddler Connection of Virginia system;
    b. Administering the Infant & Toddler Connection of Virginia system in compliance with Part C of IDEA;
    c. Taking appropriate action to identify and coordinate all available resources for early intervention services within the State, including those from Federal, State, local, and private sources;
    d. Monitoring programs and activities used by the State to carry out its obligations under Part C, whether or not these programs or activities are receiving assistance under Part C, to ensure that the State complies with Part C;
    e. Monitoring Part C compliance of agencies, institutions, and organizations used by the State to carry out Part C requirements, ensuring enforcement of any requirements imposed by law on those agencies, institutions and organizations; and providing technical assistance, if necessary;
    f. Ensuring correction of deficiencies that are identified through monitoring and supervision activities;
    g. Entering into formal interagency agreements with other State-level agencies involved in the State's early intervention program;
    h. Establishing or adopting procedural safeguards that meet the requirements of Part C;
    i. Ensuring effective implementation of procedural safeguards by each public agency in the State that is involved in the provision of early intervention services; and
    j. Developing and implementing State regulations, policies and procedures and a Practice Manual to ensure consistent statewide program implementation among the participating agencies;
2. Develop public awareness materials about Virginia's early intervention system and the child find system including the purpose and scope of the system, how to make referrals, and how to gain access to an eligibility determination, services and the central directory. Materials shall be posted on the Infant & Toddler Connection of Virginia web site, www.infantva.org;
3. Accept joint responsibility with the Department of Education to locate and identify all infants and toddlers potentially eligible under Part C or Part B, given the parallel requirements for child find under Part B and Part C of IDEA. Local interagency agreements shall identify the specific responsibilities of local school divisions and the local Part C lead agency with regard to local child find procedures;
4. Contract with local lead agencies for administration of local early intervention systems across Virginia;
5. Ensure that local policies, procedures, and mechanisms are in place statewide to receive referrals through the Department of Social Services, in accordance with federal and state Child Abuse and Prevention Treatment Act (CAPTA) regulations,

and to make an individualized determination about the child's eligibility for Part C; and

6. Provide ongoing training and technical assistance in collaboration with the Virginia Department of Education to local lead agencies, Part C service providers, local school division personnel and families on areas of joint responsibility, including but not limited to transition, child find and data collection.

B. The Department of Health (VDH) shall:

1. Provide families with information about Part C early intervention services as well as EPSDT and public health services through the Virginia Family Helpline and Children's Special Health Care Services (CSHCS);
2. Make available the services of the following programs and entities to infants, toddlers and their families who are eligible for each service, within available resources:
    a. Care Connection for Children (CCC);
    b. Child Development Services (CDS);
    c. Bleeding Disorders Program (BDP);
    d. Genetics and Newborn Screening (GNS);
    e. Pediatric Comprehensive Sickle Cell Services; and
    f. The thirty-three local health districts that are units of VDH; and
3. Work with other state and local agencies in child find activities and be involved in development of IFSPs as appropriate.

C. The Department of Education (DOE) shall:

1. Accept joint responsibility with DBHDS to locate and identify all infants and toddlers potentially eligible under Part C or Part B, given the parallel requirements for child find under Part B and Part C of IDEA. Local interagency agreements shall identify the specific responsibilities of local school divisions and the local Part C lead agency with regard to local child find procedures; and
2. Provide ongoing training and technical assistance in collaboration with the DBHDS to local lead agencies, Part C service providers, local school division personnel and families on areas of joint responsibility, including, but not limited to, transition, child find and data collection.

D. The Department of Social Services (DSS) shall:

1. Refer any child under the age of three who is the subject of a founded child abuse/neglect disposition to the local Infant & Toddler Connection of Virginia;
2. Encourage local Child Protective Services supervisors and workers to make referrals to the Infant & Toddler Connection of Virginia for any children under three who appear developmentally delayed or who have a physical or mental condition that has a high probability of resulting in delay, even for children for whom there is not a founded child abuse/neglect disposition.

E. The Department of Medical Assistance Services (DMAS) shall:

1. Added a new subsection, 5.0A entitled "Early Intervention Services" as more fully set forth in Interagency Agreement No. 137-07 (IAG No 137-07), signed between the parties March 28, 2007. The purpose of this Modification is to provide a means for service provision and reimbursement of Early Intervention Services between the two agencies, under the State Medical Assistance Plan for Medicaid, and under the State Child Health Plan for FAMIS.
2. This modification is subject to all applicable security and confidentiality limitation described in IAG 137-07, initially signed between the parties March 28, 2007.
3. Provide full reimbursement of Part C services that are covered under the State Medical Assistance Plan for Medicaid and under the State Child Health Plan for FAMIS.
4. DBHDS shall transfer to DMAS the state funds to cover the state share of services for early intervention performed by "non-traditional" providers designated as $2.3 million in general funds every state fiscal year. DMAS shall draw Medicaid and FAMIS federal

funds as well as state general funds in order to cover the total cost of EI services, and make necessary payments to the providers. The expenses shall be reported on DMAS records as of year-end.

5. Except as provided herein, all terms and conditions of Interagency Agreement No. 137-07, originally signed between the parties on March 28, 2007 and heretofore amended, remain unchanged and in full force.

F. The Department for the Blind and Vision Impaired (DBVI) shall:

1. Refer to the Infant & Toddler Connection of Virginia infants, toddlers and families who become known to the Department through its regional offices who may be eligible under Part C; and
2. Provide Part C early intervention services including vision assessment, vision services, family training and counseling, assistive technology, and IFSP development, as follows, for children who are eligible for Part C and blind or vision impaired:
    a. Assistive technology: DBVI shall offer assistive technology information related to infants with visual disabilities;
    b. Family training and counseling: DBVI staff shall provide technical assistance and materials that parents use with their child;
    c. Participation in multidisciplinary assessments: DBVI staff shall provide vision related assessments as part of the team;
    d. Coordination of agency services: DBVI staff shall work with the family's service coordinator to coordinate agency services with those of other service providers in the community;
    e. Vision services and developmental services: DBVI staff shall offer all vision services that are included in Virginia's Part C definition of vision services; and
    f. Development of Individualized Family Service Plans (IFSP): DBVI staff shall participate on the IFSP team to help develop goals and strategies for eligible children and their families.

G. Department for the Deaf and Hard of Hearing (DDHH) shall:

1. Provide technical assistance and resources to local lead agencies, Part C service providers, and families on topics related to screening, assessment and services for children who are deaf or hard of hearing and their families.

VIII. DISPUTE RESOLUTION

In instances of interagency conflict, every effort shall be made to resolve the differences at the lowest level possible. In the event of a difference of opinion in any matter related to the implementation of this agreement, disagreements regarding systemic issues of responsibility for service provision or compliance with the interagency agreement, the participating agencies agree to the following procedures for resolution of disputes:

1. Participating agencies shall make every effort to resolve their own disputes according to the procedures within their agency. If a dispute involves two or more state agencies, resolution shall first be attempted through discussion between the state agencies involved.
2. If participating agencies are unable to resolve disputes in a timely manner, a participating agency may forward a written request to DBHDS, the State Lead Agency, to initiate a state-level interagency dispute. The written request shall include a written summary of the steps taken to resolve the interagency dispute and a written summary of findings.
3. Upon receipt of a written request from a participating agency to initiate an interagency dispute, the following steps shall be taken:
    a. DBHDS shall review all materials submitted to determine if the request warrants the initiation of the state-level interagency dispute process or if the dispute needs to be resolved through other channels
    b. If DBHDS determines the dispute needs to be resolved through the state-level

interagency dispute process, the dispute shall be referred to the Commissioner of DBHDS, or his designee, for resolution.

c. If the dispute cannot be resolved by DBHDS, then the dispute shall be referred to the Secretary of Health and Human Resources and/or the Secretary of Education for resolution.
d. If the dispute cannot be resolved by the Secretary(ies) within 30 days, the dispute shall be referred to the Governor.
e. When resolutions of disputes are reached at any level, the resolution, as well as any actions to be taken by the involved parties, shall be in writing and shall be binding on all parties.

4. During the pendency of a dispute, the Governor, who is responsible for assigning financial responsibility among the appropriate agencies, shall:
   a. Assign financial responsibility to an agency; or
   b. Assign DBHDS as the State Lead Agency to pay for the support or service, in accordance with Part C payor of last resort provisions.
5. If, during resolution of the dispute by DBHDS, the Governor determines that the assignment of financial responsibility was inappropriately made, the:
   a. Governor shall reassign the responsibility to the appropriate agency; and
   b. DBHDS shall make arrangements for reimbursement of any expenditures incurred by the agency originally assigned responsibility.
6. If a participating agency fails to provide or pay for the supports and services pursuant to the interagency agreement:
   a. DBHDS shall provide or pay for the provision of such supports and services to the child.
   b. DBHDS shall claim reimbursement for the supports and services from the participating agency that failed to provide or pay for such supports and services and such participating agency shall reimburse DBHDS pursuant to the terms of the interagency agreement.

IX. DURATION OF AGREEMENT

This agreement is effective on the date of signature. This agreement shall be reviewed periodically and revised as necessary with the agreement of all participating agencies.

5/5/10

Margaret Schultze, Interim Commissioner
Department of Social Services

James W. Stewart, III, Commissioner
Department of Behavioral Health and Developmental Services