



NEW JERSEY DEPARTMENT
OF CHILDREN AND FAMILIES

New Jersey Department of Children and Families Policy Manual

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Subchapter:	1	Allegation-Based System	
Issuance:	100	Allegation-Based System (ABS)	

Purpose:

This issuance establishes the new indicators of harm for the allegation-based system (ABS). The indicators provide guidance on how to determine and support a case finding. The prior ABS consisted of 32 allegations – now there are 15 indicators of harm. Additionally, there are four new indicators that were coded under substantial risk of physical injury/environment injurious to health and welfare. During our investigative work and practice with our children and families, these risk factors are co-occurring with child abuse and neglect.

The four new Indicators of Harm include: Family Violence Harms the Child; Mental Illness of a Caregiver threatens a child; Substance Use Disorder of a Caregiver Harms the Child and Risk of Harm.

Policy:

1. Abandonment (Neglect)

Must be selected as a category when parental conduct that demonstrates the purpose of relinquishing all parental rights and claims to the child is apparent. It is also defined as any parental or caregiver conduct which shows a settled purpose to forego all parental duties and relinquish all parental claims to the child. Conduct on the part of the parent, which indicates they have no intention now or in the future to maintain any degree of interest, concern or responsibility for the child.

Examples include but are not limited to parents who:

- Leave a baby on the doorstep;
- Leave a baby in a garbage can;
- Leave a child with no apparent intention to return; and or,
- Leave a child with an appropriate caregiver but fail to resume care of the child as agreed, and the caregiver cannot or will not continue to care for the child.

How to Determine and Support a Case Finding:

The Worker must ensure that the child receives an immediate medical examination if evidence exists that the child is in need of urgent medical care. Medical records of current treatment/diagnosis and relevant past treatment is required

If police have conducted an investigation, the final police report must be obtained and documented. If the police report is not available, a case note must be included indicating the report has been requested along with documentation of the verbal statements. The Supervisor must review the Police report when it is received to ensure findings do not conflict with previously documented information received verbally.

2. Death or Near-Fatality of a Child (Physical Abuse/Neglect)

Must be selected as a category when permanent cessation of all vital functions to include cerebral function, spontaneous function of the respiratory system, and spontaneous function of the circulatory system.

“Near Fatality of a Child” must be selected when a child was placed in serious or critical condition as a result of an act of abuse or neglect.

The child’s serious or critical condition must be classified/certified by the treating physician. The serious or critical condition must be evidenced in the medical chart or reflected in the hospital record.

Examples include but are not limited to:

- A child suffers severe childhood injury or condition caused by abuse or neglect
- A child suffers a severe, permanent mental or physical impairment

- A child suffers a life-threatening injury
- A child suffers a condition that creates a probability of death within the near future
- A child is receiving critical care at the hospital that could include being in “serious condition or critical condition”.
- A child has been deemed to be in “critical condition”. The child’s vital signs are unstable and not within normal limits. The child may be unconscious, and the indicators/prognosis are unfavorable
- A child has been deemed to be in “serious condition”. The child’s vital signs maybe unstable and not within normal limits. The child is acutely ill and the indicators/ prognosis is questionable
- A child suffers a near drowning incident where life-saving intervention was administered.

How to Determine and Support a Case Finding:

- 1) Verification that the child is dead or suffered a near fatality (such verification must come from a physician, coroner, or medical examiner). The serious or critical condition must be evidenced in the medical chart or reflected in the hospital record.
- 2) Autopsy results and findings including a copy of the autopsy report. If the autopsy report is not available, a case note must be included indicating the report has been requested along with documentation of the verbal statements regarding the cause and manner of death. The Supervisor must review the autopsy report when it is received to ensure findings do not conflict with previously documented information received verbally. (for death of child)
- 3) Medical exam of all other children residing in the home where a child died. (Any request to waive medical exam must be approved by LOM)
- 4) Interview the Coroner/Medical Examiner to determine cause of death/autopsy results. (for death of child)
- 5) Victim’s medical records including those that detail any medical procedure just prior to death and relevant medical reports of past treatment.
- 6) Medical records of other surviving children if potentially relevant to the case decision.
- 7) Photographs (if available) of fatal injuries.
- 8) Interview the physician who treated the current condition if other than reporter/source.
- 9) Interview the victim’s primary care physician and other physicians that treated the child within the past six months.

- 10) Interview hospital personnel if victim was transported to hospital for treatment.
- 11) Interview paramedics who were called to the scene.
- 12) Interview police/investigative law enforcement officers who were called to the scene and/or involved in investigation. Obtain police reports.
- 13) Observe the environment where the maltreatment occurred and photograph.
- 14) Interview child protective services in other states in which the family members have resided.
- 15) Circumstantial evidence, which points to a specific perpetrator, or most likely perpetrator. Consult with a DAG when unable to determine the actual perpetrator and have multiple suspects.
- 16) A second medical examiner or coroner's opinion must be obtained when:
 - a) The coroner is unable or unwilling to offer an opinion regarding the cause of death; or there are conflicting opinions among authorities; or
 - b) The case has been staffed with a supervisor and, based on the totality of the information gathered,
 - c) The CPS investigator is unable to make a well-supported finding.
- 17) The Child Fatality and Near Fatality Regional Board must be consulted when a disagreement exists.

[Click Here to View or Print the Critical Incident Reporting Policy](#)

3. Educational Neglect (Neglect)

Must be selected as a category when the parent or caregiver has willfully failed to provide a school-age child with a regular education, as prescribed by applicable State law. In addition to being a violation of applicable law, Educational neglect has a substantial and prolonged impact on the child victim.

Any public or private school official, member of a local board of education, or judge or court official who has reason to believe that a child is enrolled in school but not attending due to the willful actions or inactions of the parent or caregiver. The local school system or board of education must exhaust all its remedies, under State education law, administrative code and local programs and procedures to engage the parent or caregiver and compel the child to attend school, before making a report of "educational neglect."

Examples include but are not limited to parent(s) who:

- Permits chronic truancy, permits habitual absenteeism from school, (e.g., the parent or guardian is informed of the problem and does not attempt to intervene).
- Fails to enroll or other truancy, fails to homeschool, fails to register, or fails to enroll a child of mandatory school age into school, causing the child to miss at least 1 month of school without valid reasons; or
- Fails to address the special education needs and are refusing to allow or fails to obtain recommended remedial education services or neglecting to obtain or follow through with treatment for a child's diagnosed learning disorder or other special education need without reasonable cause.

How to Determine and Support a Case Finding:

- 1) Determine and provide documentation from the appropriate school district, that the child is school-age is not enrolled in either a public or private school or being home-schooled.
- 2) Verify and provide documentation of any court involvement or intervention under the NJ Education Law.
- 3) Determine any impact to the child based upon past and current school records, report cards, and any professional assessment deemed necessary to make that determination.
- 4) It may be necessary to consult with the Clinical or Educational Liaison, on a case-by-case basis, to make specific to determine what assessments are appropriate.

4. Failure to Provide Basic Needs (Neglect)

Failure on the part of the caregiver to provide adequate provisions for a child.

Note: Please remember when selecting the “Failure to Provide Basic Needs,” the Worker indicates in his or her narrative what subcategory the concerns are regarding (e.g., Failure to Provide Basic Needs for Inadequate Food or Inadequate Shelter etc.).

This includes the following:

- A) **Inadequate Clothing**-insufficient clothing to protect the child from the elements;

- B) **Inadequate Food**- lack of food adequate to sustain normal functioning (examples include a child who frequently and repeatedly misses meals, fed insufficient amounts of food, who asks neighbors for food, fed unwholesome foods when his age, developmental stage, and physical condition are considered);
- C) **Lock Out**- a parent/caregiver has denied the child access to the home and has refused or failed to make provisions for another living arrangement; or
- D) **Inadequate Shelter or Environment**- lack of shelter which is safe and which protects the child from the elements OR living conditions are unsanitary to the point the child's health may be impaired (e.g., infestations of rodents, insects, feces, rotten food or spoiled garbage that child can reach; no housing or condemned housing, housing with exposed / frayed wiring, indoor temperatures consistently below 50 degrees F, a fire hazard obvious to the reasonable person, or an unsafe heat source which can include threat of asphyxiation).

How to Determine and Support a Finding:

- 1) Child's age and developmental stage. (Is the child able make appropriate judgments regarding food, clothing? Does the condition of the shelter/environment pose a higher risk to the child because of age or developmental stage?)
- 2) Child's physical condition. (Does the child require a special diet? Does the child have a physical condition/disability which is aggravated by exposure to the elements? Does the condition of the shelter/environment pose a higher risk to the child because of a physical condition/disability?)
- 3) The child's mental abilities. (Is the child able to obtain and prepare his own food? Does the child have the ability to obtain appropriate clothing? Does the child comprehend the dangers posed by the inadequate shelter/environment?)
- 4) Consult with local Board of Health and/or fire department when assessing appropriate shelter.
- 5) Observe and photograph the clothing/environment/lack of food.
- 6) Consider severity, frequency, duration, chronicity or pattern of the occurrence.
- 7) Consider availability or access to adequate food/clothing/shelter.
- 8) Weather conditions (used when assessing clothing/shelter/living arrangements). What is the severity of the condition? (frostbite, hypothermia, extreme heat or cold)

- 9) Parental inability to provide for the alleged victim in the home setting due to the alleged victim's serious mental illness, violent, threatening behavior, sexual abuse of a sibling or criminal activities which place family members at serious risk. Parental inability to independently access the necessary correctional, therapeutic or structured services. Has the parent tried informal placements which have failed? Is the alleged victim willing to return home? Participate in services? (used when assessing failure to provide appropriate living arrangement)
- 10) Detailed explanatory statements of the victim, perpetrator, witnesses, and any other person with knowledge of the condition have been obtained.
- 11) If police have conducted an investigation, the final finding must be obtained and documented. If the police report is not available, a case note must be included indicating the report has been requested along with documentation of the verbal statements. The supervisor must review police report when it is received to ensure findings do not conflict with previously documented information received verbally.

5. Family Violence harms the Child (Physical Abuse/Emotional Abuse/Neglect)

Must be selected when one of the following values is present. Note: Most of these incidents of Family Violence will fall under the category of Neglect or Physical Abuse.

A) Domestic Violence -

- 1) Physical violence which one intimate partner inflicts upon another where at least one partner resides within the home with the child or the physical violence occurred in the presence of the child during visitation with parents. Partners may be married, dating or separated, living together or in separate dwellings, heterosexual, gay or lesbian. Violence includes hitting, pushing, shoving and other intimidating acts where a partner or his or her child's physical safety, risk of future physical danger and or neglect has been threatened or is at significant risk.
- 2) Coercive Controlling Tactics: Domestic violence may also occur as coercive controlling tactics used by one intimate partner against the other which may directly and indirectly significantly impact the child. This pattern of behavior may include including physical abuse, verbal abuse, isolation, sexual abuse, threats, intimidation, emotional abuse, economic

control, deprivation of rights and freedom, and the abuse and/or neglect of children.

Examples include but are not limited to:

- Impeding the care of the children; his or her access to medical professionals, therapy, school, family/friends.
- Alleged perpetrator's behaviors, inclusive or verbal or emotional abuse create danger or harm to the child.
- Threats of violence toward any family member or family pets.

B) Adult Violence –

Any violent criminal behavior, such as assault or battery, perpetrated on one adult household member by another (that does not fall under that category of domestic violence), which could also result in injury to a child.

How to Determine and Support a Case Finding:

- 1) Document the alleged perpetrator's behavior as the source of risk or safety concern for the children. This documentation should gather the alleged perpetrator's pattern of behavior for DV (this may include collateral contacts, witness interviews, and child interviews). Documentation should include:
- 2) Severity and frequency of the alleged perpetrator's behavior
- 3) Specific incidents of coercion and control
- 4) Specific incidents of physical violence
- 5) Specific incidents of psychological or emotional harm
- 6) Documentation of attempts of the alleged perpetrator to inflict or inflicting physical, psychological or emotional harm to the child. (This may include limiting access to or withholding medical or basic needs including food, transportation, finances, etc.).
- 7) Documentation of the age, delayed developmental status, documentable emotional impact, or other vulnerability of the child.
- 8) Evidence or documentation that the child was injured because of intervening or attempting to intervene during a physical assault by the alleged perpetrator.
- 9) Document any ways in which the alleged perpetrator's behavior impacts his or her ability to parent the child(ren). How does this then impact the child(ren)?

- 10) Describe in detail, any access that the alleged perpetrator has to the child(ren) and how this impacts the safety or risk of harm to the child(ren).
- 11) Include any medical or other professional reports that were obtained as a part of the investigation.
- 12) Is there any court involvement, court orders, restraining orders, or conditions of probation?

Specific Questions for Domestic Violence:

- 1) During the incident(s), did the child intervene to protect the non-offending parent?
- 2) Did the child intervene to contribute to the violence or coercive tactics?
- 3) Was the child present and/or witness the incident?
- 4) During the incident(s), did an assault on the child occur?
- 5) During the incident(s), was the child inadvertently harmed even though he/she was not the actual target of the violence?
- 6) What was the nature and severity of the occurrence?
- 7) What was the impact to the child? (e.g., behavioral, emotional, social, educational or developmental)
- 8) What was the direct or indirect involvement of the children in the pattern of behavior?
- 9) Were the police called for the occurrence? How many times have they been to this address and were their responses indicative of a pattern of domestic violence?
- 10) Are there weapons in the home the alleged perpetrator can access?
- 11) What is the role of substance use, mental health, and culture?

6. Human Trafficking (Physical Abuse/Emotional Abuse/Sexual Abuse/Neglect)

Human Trafficking must be selected when one of the values is present.

- A) **Servitude**- The condition whereby a child is forced to perform labor or services against his or her will. This includes, but is not limited to:
Forced Work at public establishment;
Labor Camps; or
Domestic Servitude.

How to Determine and Support a Case Finding of Servitude:

- 1) Victim statement alleging human trafficking through forced labor or services. If CP&P conducted a joint interview with law enforcement, documentation of victim statement should include notes from the criminal investigation.
- 2) Secure evidence that the victim was trafficked by a parent/caregiver (NEGLECT), or the parent/caregiver failed to stop the action of another person that resulted in trafficking (NEGLECT).
- 3) Document the typology of the incident stating the type and extent of forced conduct (e.g. what was said and context, what was viewed, and circumstances, details of exposure, etc.).
- 4) If physical evidence is unavailable, investigator should document a basic consistency between statements and supporting information (corroboration) regarding time(s), place, physical descriptions, and whereabouts of others living at the address at time of occurrence, etc.
- 5) Detailed documentation of perpetrator's statement.
- 6) If police have conducted an investigation, the final finding must be obtained and documented. If the police report is not available, a case note must be included indicating the report has been requested along with documentation of the verbal statements. The Supervisor must review the police report when it is received to ensure findings do not conflict with previously documented information received verbally.
- 7) If multiple perpetrators are identified, circumstantial evidence that identifies the most likely perpetrator.
- 8) If behavioral/emotional problems are used as corroboration, statement from clinician regarding correlation.

Note: Consult the County Prosecutor/investigating police officer before interviewing the child victim, to avoid compromising the investigation. Determine if a joint investigation is possible, to facilitate holding a single interview with the child victim, to lessen trauma to the child, and to strengthen both the criminal (law enforcement) and the civil (CP&P) investigations. If the child victim is believed to be unsafe, take action, as necessary, to assure his or her immediate safety.

Required Medical Documentation and/or Consultations:

- 1) The Worker must ensure that the child receives an immediate medical examination if evidence exists that the child is in need of urgent medical care.
- 2) The Worker must ensure that the medical examination screens for beatings, broken bones, untreated wounds and injuries.

- 3) The Worker must ensure the screening of mental health problems, including post-traumatic stress disorder.
- 4) The Worker must secure medical records of current treatment/diagnosis and relevant past treatment.
- 5) A second opinion is required when:
 - a. The treating physicians are unable or unwilling to offer an opinion regarding whether abuse occurred;
 - b. There are conflicting opinions among treating physicians; or
 - c. The case has been staffed with a Supervisor and, based on the totality of the information gathered; the assigned Child Protective Investigator is unable to make a well-supported finding.

Note: The opinion of the physician with the most relevant specialization and experience should be given the greatest regard. Additional clinical consultation may be sought if the victim recants during the investigation, or if the victim's ability to make a statement is impaired due to emotional developmental, behavioral problems, etc.

The following must be contacted within 24 hours of receiving the report:

- 1) NJ Office of the Attorney General at the 24-hour NJ Human Trafficking Hotline at 877-986-7534.
- 2) Polaris Project's at the National Human Trafficking Hotline at 888 373-7888.
- 3) The Prosecutor must be notified within 24 hours after receipt of the report.
- 4) CP&P and local law enforcement should cooperate in conducting investigations.

B) Sexual Exploitation- Sexual use of a child for advantage, or profit.

This includes, but is not limited to:

- 1) Indecent solicitation of a child.
- 2) Child pornography.
- 3) Sex with a child for money, drugs, shelter etc.; or
- 4) Sex tourism.

How to Determine Support a Case Finding

- 1) Victim statement alleging sexual exploitation. Note exploitation definition, which requires documentation that the sexual use of a child was for purposes of profit. If CP&P conducted a joint interview with law enforcement, documentation of victim statement should include notes from the criminal investigation.
- 2) Secure evidence that the victim was sexually trafficked by a parent/caregiver (ABUSE), or the parent/caregiver failed to stop the action of another person that resulted in exploitation (ABUSE).
- 3) Document the typology of the incident stating the type and extent of sexual conduct (e.g. what was said and context, what was viewed, and circumstances, details of exposure, etc.).
- 4) If physical evidence is unavailable, investigator should document a basic consistency between statements and supporting information (corroboration) regarding time(s), place, physical descriptions, and whereabouts of others living at the address at time of occurrence, etc.
- 5) Detailed documentation of perpetrator's statement.
- 6) If police have investigated, the final finding must be obtained and documented. If the police report is not available, a case note must be included indicating the report has been requested along with documentation of the verbal statements. The Supervisor must review the police report when it is received to ensure findings do not conflict with previously documented information received verbally.
- 7) If multiple perpetrators are identified, circumstantial evidence that identifies the most likely perpetrator.
- 8) If behavioral/emotional problems are used as corroboration, statement from clinician regarding correlation.
- 9) Every effort must be made to assess credibility of all subjects involved in the investigation.
- 10) The Prosecutor must be notified within 24 hours after receipt of the report.
- 11) CP&P and local law enforcement should cooperate in conducting investigations.
- 12) Written approval -- The above elements are required for every investigation into human trafficking – sexual exploitation. The Supervisor's approval is required, in writing, if it is acceptable for any of the above-steps to be eliminated from the investigation process.
- 13) The Supervisor documents his or her approval on a NJ SPIRIT Contact Activity Note, printable as a Contact Sheet, [Form 26-52](#).

Required Medical Information and/or Consultations

- 1) The Worker must ensure that the child receives an immediate medical examination if evidence exists that the child needs urgent medical care.

- 2) The Worker ensures that the medical examination screens for beatings, broken bones, untreated wounds and injuries.
- 3) The Worker ensures the screening of reproductive health problems, including HIV exposure and other sexually transmitted disease, fertility issues, and gynecological diagnoses associated with rape and sexual violence.
- 4) The Worker ensures the screening of mental health problems, including post-traumatic stress disorder.
- 5) The Worker ensures the screening of substance use issues.
- 6) Medical records of current treatment/diagnosis and relevant past treatment.
- 7) A second opinion is required when:
 - a) The treating physicians are unable or unwilling to offer an opinion regarding whether or not abuse occurred; or
 - b) There are conflicting opinions among treating physicians; or
 - c) The case has been staffed with a Supervisor, and, based on the totality of the information gathered; the assigned Child Protective Investigator is unable to make a well-supported finding.

Note: The opinion of the physician with the most relevant specialization and experience should be given the greatest regard. Additional clinical consultation may be sought if the victim recants during the investigation, or if the victim's ability to make a statement is impaired due to emotional developmental, behavioral problems, etc.

The following must be contacted within 24 hours of receiving the report:

- 1) NJ Office of the Attorney General at the 24-hour NJ Human Trafficking Hotline at 877-986-7534; and
- 2) The Polaris Project's at the National Human Trafficking Hotline at 888-373-7888.
- 3) The Prosecutor must be notified within 24 hours after receipt of the report.
- 4) CP&P and local law enforcement should cooperate in conducting investigations.

[Click here to view or print Investigating Human Trafficking Allegations Policy](#)

7. Inadequate Supervision (Neglect)

Must be selected when a child(ren) has been placed in a situation or circumstance which requires judgment or actions greater than the level of maturity, physical condition, and/or mental abilities would reasonably dictate for the child(ren).

Examples below include, but are not limited to:

- Leaving children alone when they are too young to care for themselves;
- Leaving children who have a condition that requires close supervision alone. Such conditions may include medical conditions, behavioral, mental, or emotional problems, developmental disabilities or physical disabilities;
- Being present but unable to supervise because of the caregiver's condition This includes:
 - the parent or caregiver who repeatedly uses drugs or alcohol to the extent that it has the effect of producing a substantial state of stupor, unconsciousness, intoxication or irrationality; and
 - the parent or caregiver who cannot adequately supervise the child because of his or her medical condition, behavioral, mental, or emotional problems, developmental disability or physical disability).;
- Leaving children unattended in a place which is unsafe for them when his or her maturity, physical condition, and mental abilities are considered; or
- Leaving children in the care of an inadequate or inappropriate caregiver, as substantiated by the caregiver factors;
- Child consuming mood altering/dangerous/noxious substance;
- Unlocked weapons; or
- Criminal activity.

How to Determine and Support a Case Finding:

- 1) Child's age and developmental stage, particularly as it relates to the ability to make sound judgments in the event of an emergency.
- 2) Child's physical condition, particularly as it relates to the child's ability to care for or protect him or herself. Is the child physically or mentally handicapped, or otherwise in need of ongoing prescribed medical treatment such as periodic doses of insulin or other medications?
- 3) Child's mental abilities, particularly as it relates to the ability to comprehend the situation.
- 4) Determine the presence or accessibility of the caregiver to the child. Can they see/hear child? Does child know how to contact them? Has child been given

phone numbers to call in emergency? How long will it take caregiver to reach child?

- 5) Determine the caregiver's level of capability to assume responsibility in the situation. Do they depend on extraordinary assistance to care for themselves or the child? Can the caregiver physically care for themselves and the child or is there a health issue preventing that.
- 6) Determine caregiver's cognitive and emotional condition. Can the caregiver make appropriate judgments on behalf of the child; do they show signs of confusion or memory loss?
- 7) Determine frequency, and duration of occurrence. Determine the time of day or night when the incident occurs.
- 8) Determine the location of the incident and the condition the child was left unsupervised. Include weather conditions and whether there was adequate protection from the elements such as adequate heat or light.
- 9) Was the child left with his or her basic needs such as food, clothing and proper shelter?

Caregiver Factors- Assess:

- 1) Presence or accessibility of caregiver
- 2) How long does it take the caregiver to reach the child?
- 3) Can the caregiver see and hear the child?
- 4) Is the caregiver accessible by telephone?
- 5) Has the child been given phone numbers to call in the event of an emergency?

Caregiver's Capability:

- 1) Is the caregiver mature enough to assume responsibility for the situation?
- 2) Does the caregiver depend on extraordinary assistance to care for self or child?

Caregiver's Physical Condition:

- 1) Is the caregiver physically able to care for the child?
- 2) Does the caregiver's health impede his or her ability to care for the child?

Caregiver's cognitive and emotional condition:

- 1) Is the caregiver able to make appropriate judgments on the child's behalf?
- 2) Does the caregiver show signs of confusion or memory loss?

Incident Factors:

- 1) Frequency of occurrence.
- 2) Duration of the occurrence (e.g., as related to the “child factors” above).
- 3) Time of the day or night when the incident occurs.
- 4) Child’s location (e.g., the condition and location of the place where the minor was left without supervision).
- 5) Weather conditions, including whether the minor was left in a location with adequate protection from the natural elements such as adequate heat or light?
- 6) Other supporting persons who are overseeing the child (e.g., was the child given a telephone number of a person or location to call in the event of an emergency, and/or whether the child can make an emergency call).
- 7) Whether food and other provisions were left for the child.
- 8) Other factors that may endanger the health and safety of the child.
- 9) Is there a pattern of similar instances with this child or other children for whom this caregiver has been responsible?
- 10) What is the severity of the condition (e.g., identify specifics including caretaker too intoxicated to care for child, caregivers age etc.).

8. Medical Neglect (Neglect)

A) Failure to Thrive (Non-Organic)

Must be selected when a serious medical condition most often seen in children under one year of age. The child's weight, height and motor development fall significantly short of the average growth rates of normal children (e.g., below the fifth percentile). In about 10% of these cases, there is an organic cause such as a serious kidney, heart, or intestinal disease, a genetic error of metabolism or brain damage. All other cases are a result of a disturbed parent-child relationship manifested in severe physical and emotional neglect of the child.

How to Determine and Support a Case Finding:

Obtain all medical records from all medical professionals involved.
Consultation with the RDTC as appropriate.

In determining that the child has non-organic failure to thrive, the following factors should be considered:

- 1) The child's weight is below the fifth percentile of the normal range for a child of that age, but substantial weight gain occurs when the child is properly nurtured, such as when hospitalized.
- 2) The child exhibits developmental retardation which decreases when there is adequate feeding and appropriate stimulation.
- 3) Medical investigation provides no evidence that disease or medical abnormality is causing the symptoms.
- 4) The child exhibits clinical signs of deprivation which decrease in a more nurturing environment.
- 5) There appears to be a significant environmental or psycho-social disruption in the child's family.

B) Malnutrition (Non-Organic)

Lack of necessary or proper food substances in the body caused by inadequate food, lack of food, or insufficient amounts of vitamins or minerals.

How to Determine and Support a Case Finding:

- 1) Obtain all medical records from all medical professionals involved.
- 2) Consultation with the RDTC as appropriate.
- 3) The child with malnutrition is not simplistically a little version of a well-nourished child.
- 4) The various physical signs of malnutrition are:
- 5) A decrease in lean body mass or fat; very prominent ribs; the child may often be referred to as skin and bones.
- 6) Hair is often sparse, thin, dry, and is easily pulled out or falls out spontaneously.
- 7) The child is often pale and suffers from anemia.
- 8) Excessive perspiration, especially about the head.
- 9) The face appears lined and aged, often with a pinched and sharp appearance.
- 10) The skin has an old, wrinkled look with poor turgor (e.g., skin folds hang loose on the inner thigh and buttock).
- 11) The abdomen is often protuberant and
- 12) There are abnormal pulses, blood pressure, stool patterns, inter-current infections, abnormal sleep patterns and a decreased level of physical and mental activity.

C) Medical Neglect of Disabled Infants

The withholding of appropriate nutrition, hydration, medication or other medically indicated treatment from a disabled infant with a life-threatening condition, including a born alive infant.

Medically indicated treatment includes medical care which is most likely to relieve or correct all life-threatening conditions and evaluations or consultations necessary to assure that sufficient information has been gathered to make informed medical decisions. Nutrition, hydration, and medication, as appropriate for the infant's needs, are medically indicated for all disabled infants.

How to Determine and Support a Case Finding:

- 1) Obtain all medical records from all medical professionals involved.
- 2) Consultation with the RDTC as appropriate.
- 3) For Medical neglect of disabled infant, the following needs to be considered:**
 - a) The infant's physical condition.
 - b) The seriousness of the current health problem.
 - c) The probable medical outcome if the current health problem is not treated and the seriousness of that outcome.
 - d) Generally accepted medical benefits of the prescribed treatment.
 - e) Generally recognized side effects/harms associated with the prescribed treatment.
 - f) Opinions of the Infant Care Review Committee (ICRC), (if the hospital has an ICRC).
 - g) The judgment of the DCP&P Medical Director regarding whether treatment is medically indicated and whether there is credible evidence of medical neglect.
 - h) The parents' knowledge and understanding of the treatment and the probable medical outcome.

For **Medical neglect of disabled infant**, nutrition, hydration, and medication, as appropriate for the infant's needs, is medically indicated for all disabled infants.

Other types of treatment are not medically indicated when:

- 1) The infant is chronically and irreversibly comatose,
- 2) The provision of the treatment would be futile and would merely prolong dying, or
- 3) The provision of the treatment would be virtually futile and the treatment itself would be inhumane under the circumstances.

- 4) In determining whether treatment will be medically indicated reasonable medical judgments such as those made by a prudent physician knowledgeable about the case and its treatment possibilities will be respected. However, opinions about the infant's future "quality of life" are not to bear on whether a treatment is judged to be medically indicated.

D) Failure to Seek Care (Medical, Dental and/or Psychiatric)

Lack of medical, dental, or psychiatric treatment for a physical health or mental health problem or condition which, if untreated, could become severe enough to constitute a serious or long-term harm to the child; lack of follow-through on a prescribed treatment plan for a condition which could become serious enough to constitute serious or long-term harm to the child, if the plan goes unimplemented. This includes circumstances involving a parent's refusal to obtain mandated medical certification when a child has been sent home from school due to suspected alcohol/substance use.

How to Determine and Support a Case Finding:

- 1) Obtain all medical records from all medical professionals involved
- 2) Consultation with the RDTTC as appropriate
- 3) For Failure to Seek Care (Medical, Dental, and/or Psychiatric), the following should be considered:**
 - a) The child's age, particularly as it relates to the ability to obtain treatment.
 - b) Seriousness of the current health problem (e.g., medical, dental, psychiatric).
 - c) Child's physical and/or mental condition.
 - d) Child's developmental stage.
 - e) Probable outcome if the current health/mental health problem is not treated and the seriousness of that outcome.
 - f) Generally accepted medical benefits of the prescribed treatment/therapy.
 - g) Generally recognized side effects/harms associated with the prescribed treatment/therapy.

9. Mental and Emotional Impairment (Emotional Abuse/ Neglect)

Must be selected when an injury to the intellectual, emotional, or psychological development of a child as evidenced by observable and substantial impairment in

the child's ability to function within a normal range of performance and behavior, with due regard to his or her culture.

How to Determine and Support a Case Finding:

- 1) Show impairment directly related to action of the parent through evaluation by a professional.
- 2) Secure verification that a child has suffered observable and substantial impairment to his or her ability to function within a normal range of performance or behavior due to injury to the intellectual, emotional, or psychological development.
- 3) Verification must come from a psychiatrist, registered psychologist, medical doctor, registered nurse, certified Social Worker or a therapist or counselor employed by a community mental health agency.
- 4) Specific identification and documentation of parental action or behavior, which caused the mental/emotional injury (ABUSE), or the blatant disregard of parental responsibilities which led to mental injury (NEGLECT).
- 5) Identify and document the causal link between the child's mental/emotional injury and the action, behavior or blatant disregard exhibited by the parent/caregiver (e.g. the child's impairment must be directly related to the parent's action).
- 6) The Worker must ensure that the child receives an immediate medical exam if evidence exists the child needs urgent medical care.
- 7) Medical records of current treatment/diagnosis and relevant past treatment.
- 8) Expert opinion that child has suffered a mental/emotional injury as well as the suspected cause of the injury. It is necessary to document a causal relationship between the action of the caregiver and the resultant behavior of a child.
- 9) A second medical opinion must be obtained when:
 - a) The treating physician/therapist is/are unable or unwilling to offer an opinion regarding the likelihood that condition was caused by abuse or neglect; or
 - b) there are conflicting opinions among treating practitioners; or
 - c) the case has been staffed with the Supervisor and, based on the totality of information gathered, the child protective investigator is not yet able to make a well supported finding.

Note: The opinion of the physician/therapist with the most relevant specialization and experience should be given the greatest regard.

Law enforcement and Prosecutor must be notified if protective custody is taken, or the alleged perpetrator is a paramour. Notify the Prosecutor if the report constitutes a second, or more, substantiated report of abuse

10. Mental Illness of the Caregiver Threatens the Child (Emotional Abuse/Neglect)

Must be selected when risk to a child(ren) based upon the caregiver's mental illness where sound judgment and rational behavior are deemed to be deficient. The caretaker has created a real and significant risk in that his or her actions or inactions place the child at risk of harm. The existence of a mental illness does not in and of itself constitute risk.

How to Determine and Support a Finding:

The approach utilized when working with allegation of Mental Illness is broken down into three levels, each building upon the previous level:

1) Is there a mental health issue?

- a) Is the parents' mental health creating a situation of danger to the child at present creating a need for immediate intervention?
- b) Does the parent appear to be mentally unstable right now? Describe (e.g., parent is exhibiting severe depression, anxiety, isolation, flat affect, etc.).
- c) Verify past or current treatment or diagnosis looking at prescription bottles and verify usage by pill count.
- d) Look for evidence of alcohol/other drug use:
 - i. Look for empty bottles or paraphernalia
 - ii. Is the home in disarray?
 - iii. Is there an absence of food, clean clothing, clean bedding?
 - iv. Any other methods of self-medication.

2) To what extent or what level of impairment?

- a) How is the parents' actions and behavior affected by the mental health?
 - i. Are they over sleeping?
 - ii. Are they hard to wake up?
 - iii. Do they become violent?
 - iv. Are they isolated or withdrawn? Etc.
- b) How is the parents' mental health affecting other aspects of the family's daily life and/or the parent's ability to fulfill role obligations?
 - i. Are they maintaining finances?
 - ii. Are children's educational needs being met?

- iii. Are children's medical needs being met? Etc.
- c) Assess for co-morbidity of substance use, physical abuse/ DV/sexual abuse in the home.

3) What is the impact to the child?

- a) What is the age and vulnerability of the child?
- b) Is a responsible adult in the home to assume responsibility and provide care for the child?
- c) Are the mental health issues bringing a criminal element into the home?
 - i. Are these elements around the child?
 - ii. Are there frequently other persons in the home who have access to the children and may pose a threat?
- d) Does the parent drive the child/ren while impaired?
- e) Has the child(ren) been taken to all necessary well visits and had up-to-date immunizations?
- f) Is the child attending school regularly and on time, without unexplained absence?
 - i. If there are academic concerns, has the parent responded to/participated in addressing these?

Some other questions to ask during the investigation:

- 1) Who do the parents spend his or her time with?
- 2) Ask the child about the parents' behaviors and daily household routines (who cooks, cleans, and cares for the children daily).
- 3) Does his or her mood change with/without substance?
- 4) Does the parent have difficulty following through with plans? If so, what gets in the way.
- 5) Does the parent have chronic pain? Are they on prescription medication? If so which ones and what dose?
- 6) Look for patterns of neglectful behavior.

11. Physical Impairment (Abuse/Neglect)

A report taken in which a child has/had an injury which is suspected to be caused by abuse and/or neglect; and/or that a caregiver's actions could have created significant injury/impairment. The following are specific types of physical impairment:

- A) Head Injury**- A serious head injury causing skull fracture, brain damage or bleeding on the brain such as a subdural hematoma. Brain damage is injury to the large, soft mass of nerve tissue contained within the cranium/skull. A skull fracture is a broken bone of the skull. A subdural hematoma is swelling or mass of blood (usually clotted) confined to an organ, tissue or space and caused by a break in blood vessel beneath the dura mater (the outer membrane covering the spinal cord and brain). It is located beneath the membrane covering the brain and is usually the result of traumatic head injuries or the shaking of a small child or infant. It may result in loss of consciousness, seizures, mental or physical damage or death. Shaken Baby Syndrome is the shaking of an infant causing stretching and tearing of blood vessels in the brain resulting in a subdural hematoma, bleeding in the brain and/or retinal hemorrhage.
- B) Internal Injury**- An injury that is not visible from the outside: e.g. and injury to the organs occupying the thoracic or abdominal cavities. Such injury may result from a direct blow or a penetrating injury. A person so injured may be pale, cold, perspiring freely, have an anxious expression or may seem semi-comatose. Pain is usually intense at first and may continue to gradually diminish as patient grows worse.
- C) Burn/Scalding**- A tissue injury resulting from excessive exposure to thermal, chemical, electrical or radioactive agents. The effects vary according to the type, duration and intensity of the agent and the part of the body involved. Burns are normally classified as: **FIRST DEGREE**- (partial thickness) are superficial burns, damage being limited to the outer layer of the epidermis (skin); **SECOND DEGREE**- (partial thickness) are burns in which the damage extends through the outer layer of the skin into the inner layers (dermis). Blistering will be present within 24 hours; **THIRD DEGREE**- (full thickness) are burns in which both layers of skin (epidermis and dermis) are destroyed with damage extending into underlying tissues. Tissue may be charred or coagulated; **FOURTH DEGREE**- (full thickness) are burns extending beyond the skin and underlying tissues into bone, joints and muscles.
- D) Wound**- A gunshot or stabbing injury.
- E) Bone Fracture**- A broken bone. Types of bone fractures include: Epiphyseal-Metaphyseal Fractures and Diaphyseal Fractures. Epiphyseal-Metaphyseal Fractures are located at the ends of bones; they are commonly described as corner fractures, chipped fracture or bucket handle fractures. Diaphyseal

Fractures are in the bone shaft. Fractures in the shaft of long bones of the extremities are spiral (oblique) or transverse. Spiral fracture is caused by twisting or rotational force. Transverse fracture results from a direct blow or bending force.

- F) Cut, Bruise, Welt, Abrasion, and Oral Injury**- Cut (laceration) means an opening, incision or break in the skin made by some external agent. Bruise means an injury which results in bleeding under the skin, where the skin is discolored but not broken; also referred to as a contusion. Abrasion means a scraping away of the skin. Oral Injury means injuries to the child's mouth including broken teeth. Not every cut, bruise, welt, abrasion or oral injury constitutes an allegation of harm is abusive.
- G) Human Bite**- A bruise, cut or indentation in the skin caused by seizing, piercing or cutting the skin with human teeth.
- H) Sprain/Dislocation**- Sprain means trauma to a joint that causes pain and disability depending upon the degree of injury to ligaments and/or surrounding muscle tissue. In a severe sprain, ligaments and/or muscle tissue may be completely torn. The signs are rapid swelling, heat and disability, often discoloration and limitation of function. Dislocation is the displacement of any part, especially the temporary displacement of a bone from its normal position in a joint, Types include: complicated dislocation associated with other major injuries; compound dislocation in which the joint is exposed to the external air; closed dislocation is a simple dislocation and complete dislocation which completely separates surfaces of a joint.
- I) Swelling**- An abnormal enlargement of a part of the body, typically because of an accumulation of fluid.
- J) Choking/Smothering/Asphyxiation**- Choking is to cause someone to stop breathing by squeezing the throat; having severe difficulty in breathing because of a constricted or obstructed throat or a lack of air. Smothering is the deprivation of oxygen by covering of the nose and mouth. Asphyxiation is to cause someone to stop breathing often leading to unconsciousness or death.
- K) Incident without Injury**- Significant danger of physical injury; incidents of violence or intimidation directed toward the child which have not yet resulted in

injury or impairment, but which clearly threaten such injury or impairment. Placing a child in an environment which is injurious to his or her health and welfare.

L) Tying/Close Confinement- Unreasonable restriction of a child's mobility, actions or physical functioning by tying the child to a fixed (or heavy) object, tying limbs together or forcing the child to remain in a closely confined area, which restricts physical movement. Examples include, but are not limited to:

- 1) Locking a child in a closet or small room,
- 2) Tying one or more limbs to a bed, chair, or other object except as authorized by a licensed physician,
- 3) Tying a child's hands behind his or her back, or
- 4) Putting a child in a cage.

M) Providing Child with a Mood-Altering/Dangerous Substance and/or Permitting the Use of Mood-Altering/Dangerous Substance

- 1) **Providing:** The Caregiver provides the child with a mood-altering chemical, capable of intoxication, to the extent that it affects the child's health, behavior, motor coordination, judgment or intellectual capacity.

Mood altering chemicals include:

- a) Cannabis (marijuana),
- b) Hallucinogens stimulants (including cocaine), or
- c) Sedative (including alcohol and Valium),
- d) Narcotics or
- e) Inhalants.

Caregiver giving child a poison/noxious substance. Blatant disregard of parental (or other person responsible for the child's welfare) responsibilities which resulted in the child consuming poison or a noxious substance.

"Dangerous Substances" include:

- a) Poison and/or noxious substances. Poison means any substance, other than a mood altering chemical or alcohol, taken into the body by ingestion, inhalation, injection, or absorption that interferes with normal physiological functions.
 - b) Virtually, any substance can be poisonous if consumed in sufficient quantity; therefore, the term poison more often implies an excessive amount rather than the existence of a specific substance. Noxious means any substance deemed harmful (injurious); not wholesome.
- 2) **Permitting:** Failure of the parent or caregiver to take reasonable actions to prevent the child from misusing mood-altering substances (Neglect).

How to Determine and Support a Case Finding:

- 1) The Worker must ensure that the victim receives an immediate medical examination if evidence exists that the child needs urgent medical care.
- 2) Consult with the Supervisor if the child needs medical examination. A medical examination is required for all investigations regarding head injuries. (Any request to waive a medical exam must be approved by LOM).
- 3) Medical examination is required for burns in any of the following situations:
 - a) If the burn breaks the skin or blisters,
 - b) If the burn occurred to the face, head, feet and/or genitals,
 - c) If there are multiple burns, or
 - d) If the burn covers a large surface of the body, or if the burn shows signs of infection. (Any request to waive medical exam must be approved by LOM).
- 4) Consult with physician to assess appropriateness of bone scan to identify any possible past maltreatment.
- 5) Provide medical records to the treating physician and/or consultant when the records are requested or when there is a history of child injuries.
- 6) Interview the person who last saw the victim before onset of symptoms if applicable. Interview physician(s) directly involved with treatment of the reported injury.
- 7) Interview the primary care physician or physician who has seen the child in the past six months.
- 8) Secure medical documentation that the injury exists, description of the injury, age, pattern, color, size and explanation as to how occurred. For burns/scalding include: pattern, degree, percent body affected and cause.
- 9) Medical records of current treatment/diagnosis and relevant past treatment
- 10) Expert opinion to match injures with a potential cause if nature of the injury is unknown or contested. A second opinion is required when the treating physicians(s) are unable or unwilling to offer an opinion regarding the cause of injury; there are conflicting opinions among treating physician; or the case has been staffed with a Supervisor and, based on the totality of the information gathered, the Investigator is unable to make a well supported finding. (The opinion of the physician with the most relevant specialization and experience should be given the greatest weight).

- 11) Observation and photograph of the environment where maltreatment occurred. For burns/scalding the temperature of the water at the site of the incident must be measured and documented.
- 12) Child's age.
- 13) Medical condition, behavioral, mental, or emotional problems, developmental disability, or physical handicap, particularly as they relate to the child's ability to protect self/ seek help / or significantly increases a caregiver's stress level.
- 14) Pattern or chronicity of similar incidents.
- 15) Severity of injury (size, number, depth, extent of discoloration).
- 16) Location of the injury.
- 17) Whether an instrument was used on the child. Include photograph when possible.
- 18) Previous history of indicated abuse or neglect.
- 19) Interview child protective services in other states in which the family members have resided.
- 20) Circumstantial evidence, which points to a specific perpetrator or most likely perpetrator. (Consult with DAG when unable to determine actual perpetrator and have multiple suspects).
- 21) For TYING/CLOSE CONFINEMENT - Specifically identify the type of maltreatment and the nature of the harm experienced including statements explaining why the restriction of movement was unreasonable. Include a detailed description of the confining space such as the size of the space, access to help/assistance, heat/ventilation present, duration and frequency of confinement, presence or absence of lighting, reason for confinement, material used for tying and object tied to. Include photographs when possible. Identify any mental injury present especially in cases of confinement over long periods of time. If harms are identified, additional allegations should be added to the report.

12. Risk of Harm (Physical Abuse/Emotional Abuse/Sexual Abuse/Neglect)

Must be selected when the child has been placed at harm by his or her parent or his or her caregiver's conduct. This includes:

- 1) The exposure to criminal activity such as the sale or manufacturing of certain controlled substances;
- 2) The sale or distribution of weapons; witnessing or involvement to criminal activities; or

- 3) Harm or injury to one child and there is reason to believe that another child is at risk of harm. This could include:
 - a) Siblings of a victim or children to which the perpetrator is in the caregiver role;
 - b) Past child fatality; or
 - c) Past TPR or if child(ren) are in placement and there are continued concerns that the caregivers cannot adequately care for his or her child(ren).
- 4) The perpetrator's failure to comply with court orders or clearly established or agreed upon conditions designed to ensure the child's safety, such as a child safety plan or case plan.
- 5) Parental Actions or inactions that poses serious risk of harm or danger to their child(ren).

How to Determine and Support a Case Finding:

- 1) If police have investigated, the final finding must be obtained and documented. If the police report is not available, you must document that the report has been requested and document all verbal statements. The Supervisor must review police reports when they are received to ensure findings do not conflict with previously documented information received verbally.
- 2) Document the alleged perpetrator's behavior(s) that placed the child(ren) at risk or created a safety concern for the children. This documentation should gather the alleged perpetrator's pattern of behavior (this may include collateral contacts, witness interviews, and child interviews). Documentation should include:
 - a) Severity and frequency of the alleged perpetrator's behavior
 - b) Specific incidents to include dates, and locations
 - c) Documentation and reports from any law enforcement activity or involvement
 - d) Review of case history and collaboration with previous CW/Supervisors to provide a detailed account of any background showing harm done to other children by the parents that would create a risk to current child(ren).

13. Sexual Abuse

- A) Sexually Transmitted Diseases**- A disease which was acquired originally as a result of sexual penetration or sexual conduct with an individual who is afflicted with the disease.
- B) Sexual Penetration**- Any contact however slight, between the sex organ or anus of one person by an object, sex organ, mouth or anus of another person, or any intrusion, however slight, of any part of the body of one person or any animal or object into the sex organ or anus of another person.
- C) Sexual Exploitation**- Sexual use of a child for sexual arousal, gratification, advantage, or profit.
- D) Sexual Molestation**- Sexual contact with a child, when such contact, touching or interaction is used for arousal, or gratification, of sexual needs or desires.
- E) Risk of Sexual Abuse**- The parent, caregiver, or immediate family member or the parent's paramour has created a real and significant danger of sexual abuse in that:
- 1) A substantiated, registered or convicted sex offender has significant access to children, and the extent/quality of supervision during contact is unknown or , suspected to be deficient.
 - 2) There are siblings or other children in the same household as the alleged offender, or a current allegation of sexual abuse.
 - 3) Persistent, highly sexualized behavior or knowledge in a very young child (e.g. Under the age of 5 chronologically or developmentally) that is grossly age inappropriate and there is reasonable cause to believe that the most likely way this was learned is in having been sexually abused.

Contacts or interactions are considered sexual abuse when they occur between a child and a parent/caregiver, as defined in N.J.S.A. 9:6-8.21a for sexual stimulation of either that person or another person. The term additionally encompasses activities which are defined as sexual exploitation, i.e., utilizing children to perform or engage in sexual activity for a profit or gaining favor or power.

Sexual contact between a child and an adult who is in a caretaking capacity is never appropriate or justified. Sexual Abuse is an absolute under the IV Tier Model and requires a Substantiation if abuse is found to have occurred. If a child

alleges he or she was sexually abused, but there is not a preponderance of evidence of child sexual abuse then the finding is Not Established. If the child was sexually abused but the perpetrator is not a parent or caregiver, the finding is Not Established.

Sexual abuse of a child includes but is not limited to the following actions or inactions. When a child's parent or caregiver:

- 1) Rapes the child or allows the child to be raped;
- 2) Inflicts injury or allows injury to be inflicted to the child's genitals, anus, breasts, mouth through acts of coital and non-coital intercourse, manipulation, insertion of or assault with foreign objects, etc.;
- 3) Engages the child in sexual intercourse, anal intercourse, fellatio, cunnilingus;
- 4) Manipulates the child's genitals, buttocks, breasts directly or through clothing;
- 5) Has the child manipulate the perpetrator's genitals, buttocks, breasts;
- 6) Exposes his/her genitals to the child or allows the child to view another person's genitals for exhibition;
- 7) Forces, encourages, or, willfully and/or knowingly allows the child to engage in sexual activity with related or unrelated adults, children, and/or animals,
- 8) Allows, permits, or encourages the child to engage in acts in which he is sexually exploited, e.g., commercial sex act, participation in activities which are sexually explicit (or any simulation of such conduct) and which will be filmed, photographed, or otherwise depicted;
- 9) Fails to make reasonable efforts to stop an action by another person which resulted in sexual abuse; or
- 10) Allows a substantiated, registered, or convicted sex offender significant access to the child in which supervision of contact with child is found to be deficient or contact with child(ren) is prohibited (*risk of sexual harm).

How to Determine and Support a Case Finding:

- 1) Conduct a teamed investigation with law enforcement/Prosecutor to minimize the trauma of multiple interviews. Obtain statements and video of the interview which can then be used for clinical consultation which would also reduce the need to re-interview the child victim.
- 2) The Worker must ensure that the child receives an immediate medical examination if evidence exists that the child needs urgent medical care. If the child was already examined for sexual abuse and/or a rape kit was taken at a

hospital, another medical examination will not be necessary unless there is reason to suspect an additional examination is justifiable.

- 3) A sexual abuse examination is required if the child makes a statement or if information obtained suggests that any item was inserted in the vagina and/or rectum. The child's age, maturity, and time of when the insertion/penetration occurred must be taken into consideration. Whenever appropriate, an examination of this sensitive nature should be conducted by the child's medical physician/OBGYN.
- 4) Cases involving sexually transmitted infections (shift from disease to infection) requires a medical examination; including reports of attending physician regarding the type of sexually transmitted infection that afflicts the child; as well as medical records which documents the presence of the infection in the alleged perpetrator. The family's Primary Care Physician and/or OBGYN can provide the necessary examination including laboratory tests to identify if the child has or has not been exposed to a sexually transmitted infection.
- 5) Circumstantial evidence, which points to a specific perpetrator or most likely perpetrator. (Consult with DAG when unable to determine actual perpetrator and have multiple suspects).
- 6) A second medical opinion must be obtained when: The physician is unable or unwilling to offer an opinion whether abuse has occurred; or there are conflicting opinions among authorities; or the case has been staffed with a supervisor and, based on the totality of the information gathered, the CPS investigator is unable to make a well-supported finding.
- 7) Additional clinical consultation may be sought if the victim recants during the investigation, or if the victim's ability to make a statement is impaired due to emotional developmental, behavioral problems, etc.
- 8) Victim's statement alleging sexual abuse. Document the typology of the incident stating the type and extent of sexual conduct (who touched whom, where, if articles of clothing were removed, how long touching occurred, what if anything was said and context, extent of sexual conduct (digital manipulation, vaginal vs. anal penetration, oral sex), what was viewed, and circumstances, details of exposure, etc. If there is an indication that

photographs, or video was taken of the alleged abuse, contact ICE as this may lead to federal charges.

- 9) Document any physical injuries that were a result of the sexual abuse and secure any medical records which document such.
- 10) If physical evidence is unavailable, investigator should document a basic consistency between statements and supporting information (corroboration) regarding time(s), place, physical descriptions, and whereabouts of others living at address at time of occurrence.
- 11) Scene observation and demonstration with anatomically detailed dolls may provide valuable collaboration to statements provided by victim or alleged perpetrator.
- 12) If behavioral/emotional problems are used as corroboration, statement from a clinician regarding correlation should be obtained.
- 13) Medical findings that sexual abuse has more than likely occurred. (Non-verbal children);
- 14) For cases involving risk of sexual injury/harm:
 - a) Obtain verification that there was a past Substantiation or conviction of sexual abuse by a parent/caregiver, and that there has been insufficiently supervised contact with the victim.
 - b) Psychological evaluation or sex offender evaluation past or present;
 - c) clinical consultation;
 - d) frequency/severity of original offense(s);
 - e) length of time since original conviction/substantiation;
 - f) if conviction, adult or child victim, and if child, age of victim in relation to offender;
 - g) age of the original victim as it relates to current alleged victim;
 - h) relationship of original victim to offender;
 - i) length of time with current alleged victim;
 - j) any treatment received by alleged perpetrator;
 - k) age/emotional/developmental issues of current alleged victims, as it relates to his or her ability to disclose self-protective information;
 - l) current legal status of offender; other protective adults in home (e.g., access of offender).

14. Substance Use of Caregiver Threatens the Child (Physical Abuse/Emotional Abuse/Neglect)

Must be used when one of the following values is present.

- A) Caregiver Impairment**- the ingestion of one or more substances that may induce intoxication and cause cognitive, behavioral, and physiological symptoms such that the caregiver's capacity to ensure safety, provide adequate supervision, or care for a child or children is impaired.

Substances may include but not limited to:

Alcohol, cannabis, hallucinogens, inhalants, opioids, sedatives, hypnotics, anxiolytics, and stimulants.

Examples include:

- Impaired ability to ensure safety or provide adequate supervision for the child or children due to the caregiver's intoxication and/or other cognitive, behavioral, and physiological symptoms;
- Inability to abstain from substance use despite persistent or recurrent risks to the child's safety, health, and well-being resulting from the caregiver's substance use;

- B) Substance Affected Newborns**- infants who have been exposed to drugs during the pregnancy.

Examples include:

- Mother had a positive toxicology screen for a controlled substance or metabolite thereof during pregnancy or at the time of delivery,
- Newborn has a positive toxicology screen for a controlled substance after birth which is reasonably attributable to maternal controlled substance use during pregnancy,
- Newborn displays the effects of prenatal controlled substance exposure or symptoms of withdrawal resulting from prenatal controlled substance exposure,
- Newborn displays the effects of a Fetal Alcohol Spectrum Disorder (FASD) at birth.

How to Determine and Support a Case Finding:

The approach utilized when working with allegations of Substance Use is broken down into three levels, each building upon the previous level:

1) Is there a substance use issue?

- a) Describe how the parent's use of alcohol, drugs, and/or prescription pills creates a situation of immediate or impending danger to the child which requires immediate intervention. If an infant is born substance exposed, obtain certified hospital records that indicate that a substance was found in the meconium or blood of a newborn infant. Secure documentation that indicates the infant is going through withdrawal.
- b) Does the parent appear to be under the influence of drugs or alcohol right now? (e.g., parent is exhibiting slurred speech, affected gait, foul-smelling breath, etc.).
- c) If the parent/caregiver is consuming prescription medication, observe the prescription bottles, document the dosage, note the date of when the prescription was filled or re-filled, note the prescribing physician, pharmacy, and verify usage by pill count. Inquire about multiple prescribing physicians and obtain collateral information from pain management clinics/programs.
- d) Look for evidence of alcohol/other drug use such as empty pill or alcohol bottles, paraphernalia. Document the condition of the home and look for the absence of food, clean clothing, clean bedding, essentials, etc.
- e) Do the parent's recreational activities involve or revolve around substance use?

2) To what extent or what level of impairment?

- a) Describe how the parent's actions and behavior is affected by the drug/alcohol? Are they over/under sleeping? Are they hard to wake up? Do they become violent? Etc.
- b) Is the drug/alcohol chronic use and regular or an unusual or new practice by the parents(s)? Obtain certified past discharge summaries and/or substance use treatment records to verify chronicity.
- c) How does the parent's drug/alcohol use affect other aspects of the family's daily life and/or the parent's ability to fulfill role obligations? How is the substance use affecting the parent's ability to maintain their finances,

children's educational needs, his or her medical needs and his or her children's medical needs, etc.

- d) Assess for co-morbidity of mental illness, physical abuse/ DV/sexual abuse in the home.

3) What is the impact to the child?

- a) What is the age and vulnerability of the child? Describe how the child has been exposed to parental substance use. Has the child witnessed drug deals? Has the child been present for police raids or has witnessed parental arrest? Has the child seen the parent use substances? Have substances been left accessible to the child in areas the child frequents?
- b) Is a responsible adult in the home to assume responsibility and provide care for the child?
- c) Is the drug use bringing a criminal element into the home? Around the child? Are there frequently other persons in the home who have access to the children and may pose a threat? Have the police visited the home for substance use concerns? Is there a history of parental incarceration due to substance use? Are there any recent criminal charges? Obtain certified police reports.
- d) Does the parent drive the child/ren under the influence?
- e) Has the child(ren) been taken to all necessary well-visits and had up to date immunizations? Is the child(ren)'s dental visits up-to-date? Obtain certified medical and dental records.
- f) Is the child attending school regularly and on time without unexplained absences? If there are academic concerns, has the parent responded to/participated in addressing these? Obtain certified school records documenting educational concerns.
- g) Describe the stability of the child/family. Is there a pattern of homelessness and evictions? Have the utilities been shut off? Is there furniture in the home? Have there been sanctions through Social Services? If so, why?
- h) Has the parent continued to use substances despite interventions? Is there a relapse plan in place and has the parent executed the plan? Describe how past interventions have or have not improved the concerns noted under this level?
- i) Analyze all the information gathered to determine if a preponderance of evidence to suggest abuse or neglect exists. Proceed to making the correct finding in conjunction with the 4-Tier system. (Add Link to 4-tier to assist with findings).

Note: A referral for a Substance Use Assessment or to a Certified Drug and Alcohol Counselor must be strongly considered when a substance use issue is identified. Such a referral can be made at any level. However, an allegation alone without supporting evidence of a substance use issue does not warrant a referral to a Substance Use Assessment.

Additional questions to consider during the investigation:

- 1) Who do the parents spend his or her time with?
- 2) Ask the child about the parent's behaviors and daily household routines (e.g., who cooks, cleans and cares for the children daily).
- 3) Describe the parent's mood/demeanor? Describe how his or her mood/demeanor changes with/without substance?
- 4) Describe how the parents have difficulty following through with plans? If so, what gets in the way? Look for patterns of neglectful behavior

[Click here to view or print the Four Tier Findings](#)

[Click Here to View or Print Plan of Safe Care for Infants Identified at Birth and Affected by Substance Abuse Withdrawal](#)

15. Torture (Physical Abuse/Emotional Abuse)

Must be selected when factors indicate a child was subject to intense physical and/or mental pain, suffering or agony that is repetitive, increased, and/or prolonged.

How to Determine and Support a Case Finding:

- 1) Verifiable documented evidence that the child victim exhibits signs of intense physical and/or mental pain, suffering, or agony, that are the result of actions by a caregiver that were repetitive, increased, or prolonged, including a clear and concise description of the caregiver's actions. Evidence to support judgment that the identified injuries and/or conditions were the result of torturous acts.
- 2) Verify the typology of injury or condition including exact location, type and age of injury or condition, and pattern if multiple injuries or conditions are present. Include photographs.
- 3) Identify possible/plausible etiology (cause) based on available information.

- 4) If police have investigated, the final finding must be obtained and documented. If the police report is not available, you must document that the report has been requested and document all verbal statements. The Supervisor must review police reports when they are received to ensure findings do not conflict with previously documented information received verbally.
- 5) If multiple possible perpetrators are identified, gather circumstantial evidence which identifies the most likely perpetrator. DAG to be conferred if multiple possible perpetrators are identified.
- 6) Use other professionals to help "match" injury with explanation.
- 7) If physical injury has occurred because of unusual and/or cruel treatment the appropriate allegation must also be identified and investigated.
- 8) Immediate referral for medical attention if Worker believes the child is in immediate need of medical care.
- 9) Children who report or present with signs of physical or mental suffering because of torturous acts must be examined by a physician/ RDTC. This requirement can only be waived by the LOM.
- 10) Medical records of current treatment/diagnosis and relevant past treatment.
- 11) Expert opinion to match physical or mental condition with a potential cause (etiology) if nature of the injury is unknown or contested.
- 12) Consultation with physicians to assess appropriateness of long bone scans to identify any possible past maltreatment. If the torture was particularly violent, a recommendation should be made to the treating physician to do long bone scans.
- 13) A second opinion is required when:
 - a) The treating physicians are unable or unwilling to offer an opinion regarding whether abuse occurred; or
 - b) There are conflicting opinions among treating physicians; or
 - c) The case has been staffed with a Supervisor and, based on the totality of the information gathered; the child protective investigator is unable to make a well-supported finding.

Note: The opinion of the physician with the most relevant specialization and experience should be given the greatest regard. It is mandatory that the Prosecutor and law enforcement be notified at the time of the report.

Forms and Attachments:

- [Form CP&P 9-28ATT2](#), Allegation-Based System, Indicators of Harm – English to Spanish translations

Policy History:

- 6-15-2018