

SAN DIEGO COUNTY

# CHILD VICTIM- WITNESS PROTOCOL

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DEVELOPED AND UPDATED BY THE  
CPT MANAGEMENT SUB-COMMITTEE

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## POLICY STATEMENT

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### **Our Vision**

No single agency or entity can protect children alone. The agencies and organizations responsible for the community protection of children work collaboratively so that all children receive the most effective and appropriate protection possible.

### **Our Mission**

The County of San Diego and its incorporated cities will assist and protect all children, both victims and witnesses, who are exposed to any kind of abuse through a collaborative multidisciplinary team (MDT) response, also known as the Child Protection Team (CPT), which includes law enforcement, child welfare, prosecution, mental health, medical, victim advocacy, child advocacy centers (CACs) and other community providers. The MDT actively promotes diversity, equity, inclusion and anti-racist policies, practices and procedures across systems and focuses on safety, ensuring supportive service providers and enhancing protective factors with families to improve child well-being.

### **Goals of the MDT Process and This Protocol**

- Provide a centralized, coordinated, comprehensive and compassionate trauma-informed and victim-centered response to better support families through the child maltreatment investigative and prosecution process
- Establish which cases should be reviewed or seen by the CAC
- Clarify the roles, responsibilities and boundaries of each discipline
- Facilitate efficient interagency communication and information sharing to reduce duplication of efforts or gaps in service delivery, as well as limit the necessity of children having to repeat their stories more than once
- Coordinate efforts amongst agencies to increase the effectiveness of the MDT process and minimize further re-traumatization or victimization to children and families
- Promote healing and safety through linkages to CAC or other community-based specialty services (medical examinations, mental health counseling referrals, etc.)
- Adhere to evidence-based national standards

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## COMMUNITY PARTNERS

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**The following core MDT partnerships collaborate to fulfill the goals of this protocol:**

- Local Law Enforcement (LE) Jurisdictions
- County of San Diego Health and Human Services Agency (HHSA)'s Child Welfare Services (CWS); County Counsel – Juvenile Division
- District Attorney's (DA) Office – Prosecutors and Victim Assistance Program's (VAP's) DA Advocates
- Chadwick Center for Children & Families and Palomar Health's Forensic Health Services – Child Abuse Program (CAP) CAC Staff [Forensic Interviewers, mental health professionals, medical personnel and Victim/Family Advocates]

**Other community partners may include, but are not limited to:**

- Rady Children's Hospital – San Diego (RCHSD) and University of California San Diego (UCSD) medical staff
- Voices for Children – Court Appointed Special Advocates (CASA) program
- City Attorney's Office (CAO) – Prosecutors and Victim Service Coordinators (VSC)
- Family Justice Centers (FJC) – Your Safe Place (downtown) and One Safe Place (north county)
- Representatives of the United States armed forces, tribal services, community-based trauma and mental health providers, LGBTQIA+ services, Title IX Coordinators and other school district personnel, immigrant/refugee services, homeless services, San Diego Regional Center (SDRC)/Victim Assistance Support Team (VAST) and other disability services, San Diego Humane Society, Rancho Coastal Humane Society, etc.

Other community partners may be invited to participate in MDT consultation or Case Review as appropriate and necessary.

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## PENAL CODES, CONFIDENTIALITY AND INFORMATION SHARING

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The San Diego County Child Protection Team (CPT) and its agencies support interagency collaboration, cooperation and communication as members of the CPT, as detailed in the Interagency Agreement signed annually. In addition to the roles and responsibilities thoroughly detailed throughout this protocol, these agencies recognize that these goals are not legally binding and do not create a mandatory duty for purposes of civil liability. These agencies follow federal, state and local law, as well as agency-specific policy. There shall be no liability for any action or decision to follow or vary from this protocol. Investigative decisions may be based on legal requirements, agency-specific policy and case-specific needs, in consideration with the goals of this protocol.

### **Statutory Requirements for CACs**

Pursuant to California Assembly Bill (AB) 2741 and Penal Code (P.C.) 11166.4, San Diego County utilizes the Chadwick Center and Palomar Health CACs to coordinate its MDT response as described in Section 18961.7 of the California Welfare and Institutions Code (WIC) to investigate reports involving child physical or sexual abuse, exploitation or maltreatment in accordance with required standards.

Because this *Child Victim-Witness Protocol* will likely only be revised every three years, MDT partners should follow the current laws that may supersede this document.

### **Sharing MDT Information**

Pursuant to California WIC §830, the MDT “may disclose and exchange information and writings to and with one another relating to any incidents of child abuse that may also be part of a juvenile court record or otherwise designated as confidential under state law if the member of the team having that information or writing reasonably believes it is generally relevant to the prevention, identification, management, or treatment of child abuse, or the provision of child welfare services...” All MDT partners will maintain case and client confidentiality, but may disclose and exchange information and writings related to the aforementioned, as well as the investigative dispositions, which will be obtained for Case Tracking purposes. “All discussions relative to the disclosure or exchange of any such information or writings during team meetings are confidential unless disclosure is required by law.”

Pursuant to California P.C. Section 11166.4(d), “the files, reports, records, communications, and working papers used or developed in providing services through a CAC are confidential and are not public records.” Pursuant to California P.C. Section 11166.4(e), the MDT associated with the CAC “are authorized to share with other MDT members any information or records concerning the child and family and the person who is the subject of the investigation of suspected child abuse or neglect for the sole purpose of facilitating a forensic interview or case discussion or providing services to the child or family, provided, however, that the shared information or records shall be treated as confidential to the extent required by law by the receiving MDT members.”

Collaboration and communication with schools and school personnel can be necessary during the investigative response to ensure appropriate coordination and support. Information will be shared on a need-to-know basis to protect confidentiality.

### **Mandated Reporting Requirements**

The State of California has mandated reporting requirements for child abuse cases in California (P.C. sections 11164 through 11174.3). If Law Enforcement (LE) receives the child abuse report first, they must cross-report to the Child Abuse Hotline immediately or as soon as practically possible, by telephone, fax or electronic transmission (P.C.11166(k)). When a telephone report is made, a written follow-up report must be made within 36 hours. Child Welfare Services (CWS) must also cross-report cases to the appropriate Law Enforcement jurisdiction based on where the alleged crime occurred.

### **California Family Code – Consent Codes**

- 6924 – Consent by minors for mental health treatment and counseling services
- 6926 – Consent by minors for prevention/treatment of sexually transmitted infections
- 6928 – Consent by minors for medical care related to sexual assault
- 6930 – Consent by minors for medical care related to intimate partner violence

### **Sharing Investigative Information**

Best practice recommendations are that CWS and Law Enforcement share information relevant to the investigation. California P.C. section 11167 addresses reports of suspected child abuse or neglect and the sharing of such reports and related information. Per section 11167(b), “Information relevant to the incident of child abuse...may be given to an investigator from an agency [CWS or LE] that is investigating the...case of child abuse.” Additionally, subsection (c) states that such relevant information, “...including the investigation report and other pertinent materials, and information relevant to a report made pursuant to section 11166.05 may be given to the licensing agency when it is investigating a known or suspected case of child abuse or neglect.”

### **Sharing Medical Information with Investigators**

Health Insurance Portability and Accountability Act (HIPAA) and California law (45 CFR 164.512 and P.C. 11166) allow medical professionals and health care institutions to share otherwise protected health information with Law Enforcement and CWS agencies engaged in the active investigation of child abuse when the child whose medical records are requested is the subject of the investigation. Once the investigation is concluded or when the information sought involves other children not the subject of the investigation, the health care institution is prohibited from release without proper consent or a court order.

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## CULTURAL COMPETENCY AND DIVERSITY

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Culture, degree of acculturation, race/ethnicity, religion, socioeconomic status, disability, gender, gender identity/expression and sexual orientation, etc. are all factors that contribute to a child's experiences. It is important to consider, respect and accommodate important cultural factors for the child and family throughout the investigation and interventions as much as possible.

Being culturally sensitive ensures a psychologically safe environment that helps children and families of all backgrounds feel valued and respected, while also preventing further traumatization. The MDT actively promotes diversity, equity, inclusion and anti-racist policies, practices and procedures across systems in accordance with best practices from the National Child Traumatic Stress Network (NCTSN) and other nationally recognized research findings on cultural competency and diversity.

Children, family members and other related parties should not be used for translation or interpretation during an investigation because:

- It can increase trauma.
- It can put them in a situation of divided loyalty or they may fear repercussions.
- The translation may be unreliable because it may inaccurately relay information due to developmental level (vocabulary/language skills) and/or is affected by their own emotional state.
- Their own statement of what they heard or witnessed could be considered tainted or influenced due to the fact they were present and an integral part of another person's statement. It also creates credibility issues for trial.

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## INVESTIGATIVE ROLES AND RESPONSIBILITIES

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Both CWS and Law Enforcement share statutorily mandated roles in the investigation of allegations of child abuse, serious child neglect and exposure to violence. These disciplines gather facts needed to make protective decisions for the children, families and communities and to hold those who abuse and neglect children accountable in the courts when indicated.

The CWS Social Worker (SW) and the Law Enforcement (LE) Investigator both share the mutual responsibility to contact each other in a timely and respectful fashion to determine their involvement after being assigned a case. Each discipline's investigative focus has its own time constraints and legal requirements, which can result in procedural challenges. Part of the purpose of this protocol is to facilitate interagency cooperation and effective communication to address challenges.

The majority of initial Law Enforcement contacts with possible victims of child abuse and child(ren) witnessing violence are made by Patrol Officers. Agency-specific departmental policies and procedures dictate how different types of investigations are conducted. The execution of this protocol is not intended to supersede these policies. However, each Law Enforcement agency shall make every effort to follow this protocol.



## INVESTIGATIVE ROLES AND RESPONSIBILITIES (CONTINUED)

<b>Law Enforcement (LE)</b>	<b>Child Welfare Services (CWS)</b>
<b>Accept Reports - Cross Report</b>	<b>Accept Reports - Cross Report</b>
	Initial face-to-face contact with child based on assigned response priority designated by the Hotline: <ul style="list-style-type: none"> <li>• Within 24 hours</li> <li>• Within 5 days</li> <li>• Within 10 days</li> </ul>
Stabilize the scene of any crime	Make initial Safety Assessment
<b>Interview witnesses</b>	<b>Interview witnesses</b>
<b>Conduct Minimal Facts Interview (MFI), only if necessary</b>	<b>Conduct Minimal Facts Interview (MFI)</b> <ul style="list-style-type: none"> <li>• The only exception to this is when a Forensic Interview can be scheduled immediately and the CWS SW can conduct the interview on other abuse types directly following the Forensic Interview.</li> </ul>
Gather initial information – forward information to Investigator	
Assigned Investigator contacts CWS SW and exchange contact information	Contact assigned Investigator and exchange contact information
Arrange for crime scene search and collect evidence	Photo document any relevant objects or environment and any visible injuries and alert LE
Share information relevant to the investigation with CWS about past LE involvement with family and/or suspect or other adults living in the home	Share information relevant to the investigation with LE about past or current CWS involvement with family and/or suspect or other adults living in the home
<ul style="list-style-type: none"> <li>• Authorize acute medical exam in sexual assault cases</li> <li>• <b>Arrange Forensic Interview and/or Medical Exam. Notify CWS SW of interview date and time.</b></li> </ul>	<b>Arrange Forensic Interview and/or Medical Exam. Notify LE of interview date and time.</b>
<b>Interview additional witnesses</b>	<ul style="list-style-type: none"> <li>• <b>Interview additional collaterals and/or witnesses</b></li> <li>• <b>Interview caregivers/parents</b></li> </ul>
<b>Gather medical information relevant to the investigation</b>	<b>Gather medical information relevant to the investigation</b>
Take custody of a child if an immediate threat to their safety is present	<ul style="list-style-type: none"> <li>• Complete safety assessments to determine if any safety threats are identified</li> <li>• Within 48 judicial hours of a hospital hold or LE entity, a petition must be filed with Juvenile Court or the child must be released to go home</li> <li>• Take custody of a child if an immediate threat to their safety is present <b>and</b> safety threats cannot be mitigated via a safety plan</li> </ul>
<b>Share case information relevant to the investigation</b>	<b>Share case information relevant to the investigation</b>
	Make determination within 30 days of first face-to-face contact to do one of the following: <ul style="list-style-type: none"> <li>• Complete risk assessments to help inform whether CWS intervention is needed</li> <li>• Close without referrals to services</li> <li>• Close with referrals for services to community providers</li> <li>• Open Voluntary Services Case</li> <li>• File a petition with Juvenile Dependency Court (with or without removal from the home) when the safety of a child cannot be mitigated without court involvement</li> <li>• Court makes ruling as to whether the family is in need of Agency intervention</li> </ul>
Arrest suspect or submit case to DA or City Attorney for review	
Submit evidence to laboratory for testing	Perform: <ul style="list-style-type: none"> <li>• Ongoing Safety and Risk Assessment</li> <li>• Case Planning</li> <li>• Case Management</li> </ul>
Interview suspects	<ul style="list-style-type: none"> <li>• Safely care for children and reunify children to their families of origin</li> <li>• Safely support the well-being, development of permanency and lifelong relationships for children and youth</li> <li>• Provide ongoing case planning and delivery of service</li> <li>• Interview suspect(s) responsible for maltreatment</li> </ul>

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## MINIMAL FACTS INTERVIEW

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The best practice and standard of care is that children who have witnessed or been victims of trauma or abuse receive a Forensic Interview. First Responders determine probable cause and whether a crime may have occurred, identifying immediate protective actions and deciding whether a Forensic Interview and/or Medical Exam will be needed. In cases where you are unsure of whether it meets the criteria listed in the chart, a Minimal Facts Interview (MFI) should be conducted. When the information needed can be obtained from credible evidence, then the Investigator should document that information and avoid a field interview of the child.

In situations when it is necessary for Law Enforcement to gather information directly from a child who will be referred for a Forensic Interview, one designated person should be chosen to conduct a Minimal Facts Interview. This interview should seek only enough information to make immediate protective and investigative decisions. Interviewers should use the *Minimal Facts Checklist* (see *Appendix*).

CWS will gather information from all parties. These interviews should seek enough information to make immediate protective and investigative decisions. Interviewers should use the *Minimal Facts Checklist* (see *Appendix*). The only exception to this is when a Forensic Interview can be scheduled immediately and the CWS SW can conduct the interview on other abuse types directly following the Forensic Interview.

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## FORENSIC INTERVIEW

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The purpose of the Forensic Interview (FI) is to obtain as complete and accurate a report as possible from the alleged victim/witness in a manner that is developmentally appropriate and legally sound. Information gathered in the interview enables the MDT to make decisions about criminal and protective issues, as well as assessing the child and family's needs for follow-up medical, advocacy and/or mental health services.

The national standard of care, based in evidence and research, shows that Forensic Interviews conducted at a CAC are considered best practice and are trauma-informed in nature. The goal is that all alleged victims participate in the forensic interview process. Changes to the criteria can be made through the CPT Management Committee between formal reviews as requested and deemed necessary by the MDT.

### **Forensic Interviewers**

Forensic Interviewers are professionals specifically trained in using evidence-based forensic interviewing protocols and techniques; child development, including language and cognition as it applies to interviewing; abuse dynamics with an emphasis on disclosure process; childhood trauma as it relates to interviewing; special topics including interviewing young children, interviewing adolescents, interviewing children with special needs; question design and suggestibility; and cultural competency. Interviewers may utilize communication aids and facilitators (e.g., drawing paper, markers, anatomically detailed drawings, anatomic dolls) and/or introduce evidence in the interview when indicated and appropriate. Forensic Interviewers also participate in regular Peer Review for quality assurance and may also be called to testify in legal proceedings regarding their interviews or experience.

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## CRITERIA FOR FORENSIC INTERVIEWS

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Collaboration, communication and consultation with Law Enforcement, the CAC and Investigating Social Workers and Supervisors is of utmost importance. Generally, referrals are made by Law Enforcement if more than one agency is involved, but the CAC will accept referrals from CWS or Law Enforcement agencies. It is the responsibility of the referring agency to notify the other investigative agencies. The CAC can assist when needed/possible. In cases in which only one agency is involved, the referral made by that agency.

The information in this section applies only to situations in which an investigative agency has an open investigation. The term “open investigation” is defined by each individual agency’s policy, but generally means when an investigation number, referral number and/or a crime report has been generated and an Investigator has been assigned to investigate the allegations.

Levels of criteria based on the allegations defined in the chart:

- **Referral:** Referrals will be made in order to schedule a Forensic Interview for children in the noted categories unless the investigating agency specifically determines a Forensic Interview is not in the best interest of the investigation and/or the child. Investigators will follow the CAC-specific protocol for making a referral for an interview.
- **Discretionary/Consultation:** The investigating partner will consult with their Supervisor and/or other MDT partners (as needed, including the CAC) to determine if an interview is in the best interest of the investigation. If a decision is made that a Forensic Interview is appropriate, a referral will be made. If clear concerns for an interview are not present, consider whether an interview is appropriate based on the child’s previous trauma, developmental level and/or other factors. When there are differing opinions between agencies or additional questions, a consultation will be requested with the other MDT partners. Throughout the consultation process, the lead investigating agency will make the ultimate decision determining if a Forensic Interview will occur or not.

**CWS Note:** Factors to consider for Discretionary/Consultation are:

1. Is this child the subject of the referral?
2. Is there authority or consent for the interview?
3. Will it provide additional assessment information for the alleged abuse?
4. Will it help to determine if the other children in the household were also victims of abuse/neglect?

# CRITERIA FOR FORENSIC INTERVIEWS

Allegations	Description	LE	CWS
<u>Sexual Abuse</u> : Victims & Potential Victims/Witnesses* (ages 3-13)	All Sexual Abuse allegations being investigated that includes a disclosure, recantation of a disclosure and/or other evidence. <i>(For all Witnesses* categories, see definitions below chart for LE/CWS definitions.)</i>	Referral	Referral
<u>Sexual Abuse</u> : Victims & Potential Victims/Witnesses* (ages 14-17)	All Sexual Abuse allegations being investigated that includes a disclosure, recantation of a disclosure and/or other evidence. (Strongly consider <i>Referral</i> for intrafamilial and/or chronic abuse.)	Discretionary/ Consultation	Referral
<u>CSEC</u> : Initial Concerns (ages 3-13)	Child/youth has disclosed commercial sexual exploitation (CSF), or if child/youth does not disclose but concerns remain for the child/youth's safety and welfare (i.e. LE is involved, documented information on an incident of exploitation, chronic running away or other risk factors and reporting exploitation).	Referral	Referral
<u>CSEC</u> : Initial Concerns (ages 14-17)	As defined above for CSEC: Initial Concerns (ages 3-13).	Discretionary/ Consultation	Referral
<u>CSEC</u> : Ongoing Concerns (all ages)	As defined above for CSEC: Initial Concerns (ages 3-13).	Discretionary/ Consultation	Discretionary/ Consultation
<u>Physical Abuse</u> : Victims (ages 3-13)	Serious Injury as shown by: <ul style="list-style-type: none"> <li>Any act of abuse that left untreated would cause permanent physical disfigurement, permanent physical disability or death</li> <li>Injuries/bruises to a non-ambulatory child</li> <li>Acts of Cruelty – Torture</li> <li>Bite marks without verification of witnessed non-abusive event</li> <li>Burns</li> <li>Strangulation (Per CWS Family Violence Protocol, strangulation as defined by “the external compression of the neck, including the airway and blood vessels, causing reduced air and blood flow to/from the brain.”)</li> <li>Fractures considered non-accidental</li> <li>Injuries of unknown etiology</li> </ul>	Referral	Referral
<u>Physical Abuse</u> : Witnesses* (ages 3-13) <i>Only a Referral for potential witnesses to serious injuries in non-verbal children, witness to any injuries in non-ambulatory children or conflicting stories.</i>	Serious Injury as defined above in Physical Abuse: Victims (ages 3-13).	Referral	Referral
<u>Physical Abuse</u> : Witnesses* (ages 14-17) <i>Potential witnesses to serious injuries in non-verbal children, witness to any injuries in non-ambulatory children or conflicting stories.</i>	Serious Injury as defined above in Physical Abuse: Victims (ages 3-13).	Discretionary/ Consultation	Referral
<u>Physical Abuse</u> : Victims (ages 14-17) or Witnesses* (ages 3-17) <i>When victim is verbal and there are no conflicting explanations.</i>	<ul style="list-style-type: none"> <li>Serious Injury as defined above in Physical Abuse: Victims (ages 3-13).</li> <li>Minor to moderate injuries</li> </ul>	Discretionary/ Consultation	Discretionary/ Consultation
<u>Severe Neglect</u> : Victims & Witnesses* (ages 3-13)	Failure to meet basic needs for food, shelter, medical care, and/or supervision, <b>resulting in serious injury and/or near fatal conditions and/or conditions if left untreated could cause serious impairment, injury or death as shown by:</b> <ul style="list-style-type: none"> <li>Malnutrition/Nonorganic Failure to Thrive (FTT)</li> <li>Medical Neglect</li> <li>Acts of Cruelty – Starvation</li> </ul>	Referral	Referral
<u>Severe Neglect</u> : Victims & Witnesses* (ages 14-17)	As defined above for Severe Neglect: Victims & Witnesses (ages 3-13).	Discretionary/ Consultation	Referral
<u>Witness* to Severe Domestic Violence/Abuse</u> (ages 3-13)	Witness to an incident involving great bodily harm to a parent/caregiver or a caregiver causing great bodily injury to someone else (including, but not limited to: a significant or substantial physical injury and would include serious bruising or wounds, concussion, broken bones and other serious injuries).	Referral	Referral
<u>Witness* to Severe Domestic Violence/Abuse</u> (ages 14-17)	As defined above for Witness* to Severe Domestic Violence/Abuse (ages 3-13).	Discretionary/ Consultation	Discretionary/ Consultation
<u>Witness* to Severe Domestic Violence/Abuse</u> (all ages)	Strangulation, regardless of injury, as defined above for Physical Abuse: Victims (ages 3-13).	Discretionary/ Consultation	Referral
<u>Witness* to Chronic or Serious Domestic Violence/Abuse</u> (all ages)	When domestic violence has been ongoing, may include threats to cause great bodily injury (as defined above for Witness* to Severe Domestic Violence/Abuse (ages 3-13)), and no interview has been conducted in the past	Discretionary/ Consultation	Discretionary/ Consultation
<u>Witness* to Violent Crime</u> (ages 3-13)	<ul style="list-style-type: none"> <li>Homicide or Attempted Homicide</li> <li>Sexual Assault</li> <li>Kidnapping by non-custodial parent</li> </ul>	Referral	N/A
<u>Witness* to Violent Crime</u> (ages 14-17)	As defined above for Witness to Violent Crime (ages 3-13).	Discretionary/ Consultation	N/A

*Children under 3 years old or with developmental delays*

*For children under the age of 3 or individuals with a developmental disability, the Investigator will consult with the CAC to determine if the circumstances and the child's developmental abilities warrant a referral for a Forensic Interview.*

Witness\* for LE  
Witness\* for CWS

This includes all children in this age range who have been identified as possible victims/witnesses

This includes all siblings/other children in the household with an open referral/investigation who have been identified as potential witnesses.

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## CASE ACCEPTANCE CRITERIA FOR FORENSIC INTERVIEWS

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Children, youth and adults with disabilities are interviewed in a neutral, friendly and trauma-informed environment. The process for referring children for interviews varies slightly between Chadwick Center and Palomar Health. See *Appendix* for additional information and specific guidelines. The CAC will work with the Investigators regarding the appropriateness of a Forensic Interview in Discretionary/Consultation cases based on the CAC's Case Acceptance Criteria.

Criteria considerations for victims/witnesses include:

- Age/skill level
- Developmental considerations, including any delays or disabilities
- Communication skills/ability
- Physical condition (e.g., sleepy, ill, hungry, under influence of substance(s), severe injury)
- Emotional state (e.g., traumatized, overly anxious, fearful, suicidal)
- Consent
- Primary language/availability of interpretation services
- Location of victim/witness

Other considerations:

- Have all assigned MDT Investigators been notified of the interview?
- Have all assigned MDT Investigators been given the opportunity to be present to observe the interview (per protocol)?

### **Multiple/Follow Up Interviews**

One comprehensive interview may be sufficient to elicit complete information from a victim/witness. Others, due to developmental or emotional concerns, abuse dynamics or case complexity, may need multiple interview sessions that are intentionally non-duplicative. The need for Follow Up Interviews(s) and the number of interviews will be determined by the MDT.

### **Forensic Interview Process**

Forensic Interviews are conducted at both Chadwick Center for Children & Families and Palomar Health Forensic Health Services, where children are interviewed in a neutral, child-friendly environment. The process for referring children for interviews varies slightly between Chadwick Center and Palomar Health. See *Appendix* for additional information and specific guidelines.

Interviews should be referred by the investigating party and scheduled in coordination with all assigned Investigators when possible to reduce the number of interviews and Interviewers of

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the child. Timing of the interview will be determined by the MDT, taking into consideration factors that could impact the investigation, maximize productivity and minimize trauma for the victim/witness, but in general should occur as soon after the incident/disclosure as possible. Courtesy Forensic Interviews are provided with the authorization from that jurisdiction or the local jurisdiction. Prior to any interview, the Investigator(s) meet together with the Interviewer to brief them as to the nature of the allegations and investigation to date.

NOTE: The child cannot be taken from the parent by Investigators and be transported or brought to Chadwick Center/Palomar Health for the Forensic Interview without exigency, parental consent or a court order.

When an Interpreter is needed, they should be provided by the requesting Investigator. The Forensic Interviewer will prepare the Interpreter for participation in the forensic setting prior to the interview, including preparation for the difficult nature of what they may hear as well as the importance of interpreting word for word without adding information or censoring difficult content.

The interview is conducted with a single child and Interviewer. Parent(s) and/or caregivers are not allowed to remain in the interview room or observe the interview, unless clinically indicated and agreed upon by present MDT members.

Per national accreditation guidelines and best practice standards in providing trauma-informed services, the CAC and MDT must ensure there is separation of victims and their alleged perpetrator(s) during the investigative process and throughout delivery of CAC services. A known alleged perpetrator cannot be present at the CAC when the child is there for an interview or other CAC services.

All interviews are digitally recorded and may be observed by members of the investigative team. Best practice indicates that observers should include the following:

- Law Enforcement
- CWS

Other observers may include the following:

- Prosecutor
- Other investigative agency representative as dictated by the case and agreed upon by the MDT
- Trainees approved by MDT members in an observation-only role

Unauthorized observers include:

- Parents/caregivers
- Private/retained attorneys
- Court Appointed Special Advocates (CASAs)
- Others as agreed upon by MDT members present

A copy of the recording will be available to authorized agencies immediately or within 2 business days and the summary report will be provided to authorized agencies within 2 weeks

of the time of service. In situations when a member of the investigative team is unable to attend the Forensic Interview (e.g., assigned after the CAC process has been initiated), the CAC will coordinate viewing of the recorded interview to avoid re-interviewing the child.



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## MEDICAL INTERVENTION

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Many children are familiar with the helping role of Doctors and Nurses and may disclose information to medical personnel that they might not share with Investigators. The collection and documentation of possible forensically significant findings are vital. However, the referral of children for Medical Examinations should NOT be limited to those for which forensically significant information is anticipated, as the medical evaluation holds a critical place in the MDT assessment, diagnosis and treatment of child abuse as indicated in national standards of care.

Medical evaluations by Chadwick Center Child Abuse Pediatricians and/or Palomar Health Forensic Nurses are available for all children who are suspected of having been sexually abused or assaulted, regardless of ability to pay. Medical evaluations by Child Abuse Pediatricians are also available for physically abused or neglected children. The location and timing of a medical evaluation depends on case characteristics: type of abuse, timing of abuse and condition of the patient. Services can be accessed by Law Enforcement and CWS. Written reports are generated for every medical visit and are shared with the investigative parties. Additionally, medical providers providing CAC services participate in Expert Peer Review as a method of quality assurance.

The coordinated MDT approach reduces the duplication of services, and for children that had a prior Forensic Interview, provides medical personnel with important information necessary for the medical decision-making process. In turn, advanced medical providers are available for consultation regarding specialized medical evaluations and for interpretation of medical findings and reports. Additionally, it is essential for non-medical MDT members and CAC staff to undergo training regarding the nature and purpose of a medical evaluation so that they can competently respond to children and families regarding common questions, concerns and misconceptions to limit the family's anxiety or misunderstanding.

The purposes of the Medical Examination in suspected child abuse cases include the following:

- To ensure the health, safety and well-being of the child
- Evaluate, document, diagnose and address medical conditions resulting from abuse
- Differentiate medical findings that are indicative of abuse from those which may be explained by other medical conditions
- Diagnose, document and address medical conditions unrelated to abuse
- Assess the child for any developmental, emotional, mental health or behavioral problems needing further evaluation and treatment to make necessary referrals
- Reassure and educate the child and family

## **SEXUAL ABUSE**

All sexual abuse victims shall be offered the option of having a Medical Examination (information cards to be provided by the CAC). Medical Examinations may be referred by Law Enforcement, CWS or the victim themselves. The collection of deoxyribonucleic acid (DNA) forensic evidence for the purpose of prosecution can only be authorized by Law Enforcement in the jurisdiction in which the crime occurred. Evidence gathered during the course of the medical evaluation may be used for the purposes of investigation or prosecution. As such, protected health information (PHI) can be released to investigative agencies and/or court authorities as provided by Health Insurance Portability and Accountability Act (HIPAA) § 164.512 (c)(1) & (e)(1)(i). Evidence may consist of:

- Body fluids or trace evidence that has been transferred to the victim during a recent sexual abuse/assault
- Acute or healed injury and the availability of a medical professional to discuss the injury or lack of injury for the courts
- Medical history that corroborates the abuse history
- Medical test results such as sexually transmitted infections (STIs) that corroborate the abuse history

### **Acute Sexual Assault Examination**

Examination, to include DNA forensic evidence collection, should be requested if the sexual abuse/assault is very recent (within 72 hours for prepubertal females and males and 120 hours (equivalent to 5 days) for postpubertal females). If timing is in question, last known contact with the perpetrator will be used as last abusive event. A timely exam may recover body fluid and/or trace materials that will link the victim to the suspect. The timeframe can be extended with clinical consult if there are active symptoms that may be related to the abuse/assault such as pain, bleeding or discharge. Law Enforcement has the responsibility to authorize the evidence collection as the packet will need to be transported to the crime lab. The examination itself can be authorized by either CWS or Law Enforcement. These professionals should contact the on-call medical provider to discuss the case prior to sending the child for medical care because the age of the victim and post-assault hygiene may be factors in determining the timing of the exam.

### **Non-Acute Examination**

All children who disclose sexual abuse to a professional, excluding family members, or for which there is sufficient evidence of such (witness, video or photos, STIs and/or pregnancy) should be offered the option of an examination regardless of the time from the last abuse event. These exams may be referred by Law Enforcement or CWS, usually following a mandated report by a professional. There is likely no body fluid or trace material evidence to collect, however, the exam may detect healed injuries or STIs, which are definitive evidence of sexual contact. Medical history and medical test results may support the diagnosis of sexual abuse. In addition, testimony can be offered by medical staff to explain why most sexual abuse examinations are normal.

## **Consent for Sexual Abuse Examinations**

Pursuant to California Family Code Sections 6928, victims 12 years old and older may consent to their own sexual abuse exam. For victims under 12, parental consent or a court order is required except for medical emergencies or if the evidence may dissipate, such as in an acute sexual assault (*Wallis v. Spencer* (2000) 202 F. 3d 1126; WIC §324.5).

For non-emergent cases, if a parent is not available or refuses to give consent, a court order is necessary. If a parent is not on-site, but can be contacted by phone and is willing to give verbal consent for the examination of their child, this consent must be witnessed by two hospital personnel. The consent is then documented in the medical record.

Children have the right to refuse the examination and therefore their verbal consent (age 12 and above) or assent (under age 12) must be obtained prior to, or at the time of, the examination. No child will ever be forced to have an examination against their will. If a child is unconscious or otherwise incapacitated and unable to consent, a warrant can be obtained for extragenital evidence collection only. Anogenital examinations/evidence collection will be deferred until the child can consent.

## **Parental Presence at Examination**

Parents, unless they are suspected of abuse, have a right to be present at investigatory physical examinations unless there is some valid reason to exclude them. If the medical provider present believes a valid reason exists, the parents may be excluded and/or asked to remain in a waiting room or other nearby area (*Wallis v. Spencer* (2000) 202 F. 3d 1126).

Additionally, children have the right to choose their support person and can choose to not have a parent in the room during the examination. A chaperone will always be present with the medical provider in these cases. For children ages 12 and above, medical information given to the provider is protected and cannot be released without the child's consent.

## **Location of Examinations**

### Central, Eastern and Southern Jurisdictions:

- Daytime examinations, both acute and non-acute, are performed at the Chadwick Center for Children & Families at Rady Children's Hospital – San Diego, 3665 Kearny Villa Road, Fifth Floor, Suite 500, San Diego, CA 92123. Daytime contact number for patient registration and examinations is 858-966-8951.
- After-hours examinations, including weekends and holidays, are performed by SART Nurses at the Chadwick Center. Contact Rady Children's Hospital operator at 858-576-1700 ext. 0 prior to sending the child to the Chadwick Center for examination in order to coordinate a meeting time. The Child Abuse Pediatrician on-call can be

requested in order to triage cases when there is a question about the need for an emergent examination.

#### Northern Jurisdictions:

- Daytime examinations, both acute and non-acute, are performed at the Palomar Health Child Abuse Program, 1050 Los Vallecitos Boulevard, San Marcos, CA 92069. Daytime contact number for patient registration and examinations is 760-739-2150.
- For after-hours examinations, including weekends and holidays, call 1-888-211-6347 for the PBX operator who will contact the on-call Forensic Examiner 24/7/365. After-hours acute forensic medical examinations for children under 12 are performed at Palomar Health Child Abuse Program. After-hours acute forensic medical examinations for children 12 and older are performed at Palomar Health Child Abuse Program or Palomar Medical Center Poway, 15615 Pomerado Road, Poway, CA 92064. Offsite examinations can occur in emergent situations. Please call prior to arrival to allow for adequate lead time for Forensic Nursing Staff to dispatch to the exam location.

### **PHYSICAL ABUSE**

Children who have been physically abused or neglected may present with a spectrum of injuries ranging from minor to life-threatening. Both CWS and Law Enforcement, as well as medical providers, may refer an exam by a Child Abuse Pediatrician for suspected physical abuse. The purpose of the exam is to evaluate, document and diagnose suspected child abuse.

#### **Serious or Life-Threatening Physical Abuse**

These children usually present to an Emergency Department (ED) and often are admitted to Rady Children's Hospital – San Diego (RCHSD). The hospital will report suspected abuse to CWS and/or Law Enforcement. A Child Abuse Pediatrician often is asked to consult to help determine if abuse has occurred. These inpatient consultations are requested by the treating Physicians. Information from the consultation is then relayed to CWS and/or Law Enforcement Investigators.

#### **Non-Life-Threatening Physical Abuse**

These children may initially be seen in an ED, Physician's office, school, etc. The person referring for a physical abuse medical examination should call the Chadwick Center to discuss the case to determine if a medical exam would be beneficial.

#### **Consent for Physical Abuse Examinations**

For children of all ages, parental consent or a court order is required for a physical abuse evaluation. For children in CWS custody, the standard "Medical Consent to Treat" form is sufficient. If a parent is not on-site, but can be contacted by phone and is willing to give verbal consent for the examination of their child, this consent must be

witnessed by two Chadwick personnel. The consent is then documented in the medical record.

### **Parental Presence at Examination**

Parents, unless they are suspected of abuse, have a right to be present at investigatory physical examinations unless there is some valid reason to exclude them. If the medical provider present believes a valid reason exists, the parents may be excluded and/or asked to remain in a waiting room or other nearby area (*Wallis v. Spencer* (2000) 202 F. 3d 1126.).

Additionally, children have the right to choose their support person and can choose to not have a parent in the room during the examination. A chaperone will always be present with the medical provider in these cases. For children ages 12 and above, medical information given to the provider is protected and cannot be released without the child's consent.

### **Location of Examinations**

- Chadwick Center: The medical clinic is operated daily during business hours. Appointments may be scheduled by calling 858-966-8951. The CWS SW or Law Enforcement Investigator does not need to be present at the exam, but will need to supply information regarding the case to the Physicians. In some instances, an evaluation may be done by review of records, but this should only be requested when the child cannot be reasonably scheduled into clinic.
- Rady Children's Hospital – San Diego Emergency Department: If emergent medical care is required or a case cannot wait until the following day to be seen at the Chadwick Center, the ED is available. All RCHSD ED Attending Physicians have experience in child physical abuse and routinely discuss cases with the on-call Child Abuse Pediatricians.
- Naval Medical Center: Children who are dependents of a military member can be evaluated by a Child Abuse Pediatrician at the Naval Medical Center San Diego. Appointments can be scheduled in advance or the same day by calling 619-532-7353.

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## FORENSIC MEDICAL EXAMINATIONS CRITERIA

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The national standard of care, based in evidence and research, shows that Medical Examinations conducted at a CAC are considered best practice and are trauma-informed. Changes to the criteria can be made through the CPT Management Committee between formal reviews as requested and deemed necessary by the MDT.

The information in this section applies only to situations in which an investigative agency has an open investigation. The term “open investigation” is defined by each individual agency’s policy, but generally means when an investigation number, referral number and/or a crime report has been generated and an Investigator has been assigned to investigate the allegations.

Levels of criteria based on the allegations defined in the chart:

- **Referral:** Referrals will be made in order to offer to schedule a Medical Examination or Paper Consultation for children in the noted categories unless the investigating agency specifically determines a Medical Exam is not in the best interest of the investigation and/or the child. Investigators will follow the CAC-specific protocol for making a referral for an exam.
- **Discretionary/Consultation:** The investigating partner will consult with their Supervisor and/or other MDT partners (as needed, including the CAC) to determine if an exam is in the best interest of the child(ren) and investigation. If a decision is made that a Medical Examination is appropriate, a referral will be made. If clear concerns for an exam are not present, consider whether an exam is appropriate based on the child’s previous trauma, developmental level and/or other factors. When there are differing opinions between agencies or additional questions, a consultation will be requested with the other MDT partners. Throughout the consultation process, the lead investigating agency will make the ultimate decision determining if an exam will be offered or not.

**CWS Note:** Factors to consider for Discretionary/Consultation are:

1. Is this child the subject of the referral?
2. Is there authority or consent for the examination?
3. Will it provide additional assessment information for the alleged abuse?
4. Are there current injuries or medical concerns that can be evaluated?
5. Will it help to determine if the other children in the household were also victims of abuse/neglect?

## FORENSIC MEDICAL EXAMINATIONS CRITERIA

Allegations	Description	Level of Criteria Determination
<p><b>Sexual Abuse:</b> Prepubertal female victims or biologically male victims and within ~72 hours of alleged incident or contact with the potential perpetrator</p> <p><i>*See page 17 of the Protocol for additional information. Further consultation with provider at coordination of service will confirm which timeline is most appropriate based on age and physical maturation level.</i></p>	<p><i>Acute Sexual Assault Exam</i></p> <p>This should occur for any disclosure of sexual abuse/assault which is being investigated. Disclosure may have been made by the victim to a professional or other evidence may be the catalyst for investigation. Other evidence may include pictures, video, presence of a Sexually Transmitted Infection (STI), a witness statement, etc.</p>	<p>Referral</p> <p><i>NOTE: CWS and LE can both authorize, but DNA evidence collection only occurs when LE authorizes the exam.</i></p>
<p><b>Sexual Abuse:</b> Postpubertal female victims within 120 hours of alleged incident of sexual abuse</p> <p><i>*See page 17 of the Protocol for additional information. Further consultation with provider at coordination of service will confirm which timeline is most appropriate based on age and physical maturation level.</i></p>	<p><i>Acute Sexual Assault Exam</i></p> <p>Any disclosure of sexual abuse/assault which is being investigated. Disclosure may have been made by the victim to a professional or other evidence may be the catalyst for investigation. Other evidence may include pictures, video, presence of a Sexually Transmitted Infection (STI), a witness statement, etc.</p>	<p>Referral</p> <p><i>NOTE: CWS and LE can both authorize, but DNA evidence collection only occurs when LE authorizes the exam.</i></p>
<p><b>Sexual Abuse:</b> Victims of all ages outside of the timeframes noted above</p>	<p><i>Non-Acute Sexual Abuse Exam</i></p> <p>Exam for children who make a disclosure of abuse to a professional or for which external evidence is present and are outside of the timeframe of an acute exam (SART). External evidence may include pictures, video, presence of a Sexually Transmitted Infection (STI), a witness statement, etc.</p>	<p>Referral</p>
<p><b>Sexual Abuse:</b> Other Children in Household, all ages</p>	<p>Non-Acute medical exam for all children who live in the household of a confirmed victim</p>	<p>Referral</p>
<p><b>Sexual Abuse:</b> Other Children Exposed to Perpetrator, all ages (<i>NOT</i> in same household/family)</p>	<p>Non-Acute medical exam for all children who have been exposed to the perpetrator and are living in the San Diego region</p>	<p>Referral</p> <p><i>*N/A for CWS unless there is another open investigation for that family.</i></p>
<p><b>CSEC:</b> Initial Concerns, all ages</p>	<p>Child/youth has disclosed commercial sexual exploitation (CSE), or if child/youth does not disclose but concerns remain for the child/youth's safety and welfare (i.e. LE is involved, documented information on an incident of exploitation, chronic running away or other risk factors and reporting exploitation...)</p>	<p>Referral</p>
<p><b>CSEC:</b> Ongoing Concerns, all ages (Previous Exam Completed)</p>	<p>If concerns continue and child/youth has had an exam in the past 30 days (i.e. child disclosures to LE/CWS/caregivers, involvement with LE, concerns for STIs, etc.)</p> <p>If no previous exam, follow CSEC: Initial Concerns, all ages guidelines.</p>	<p>Discretionary/Consultation</p>
<p><b>Physical Abuse:</b> Victims, all ages (Current Serious Injury)</p>	<p>Serious Injury as shown by the following indicators:</p> <ul style="list-style-type: none"> <li>• Any act of abuse that left untreated would cause permanent physical disfigurement, permanent physical disability or death</li> <li>• Torture</li> <li>• Bite marks without verification of witnessed non-abusive event</li> <li>• Burns</li> <li>• Strangulation (Per CWS Family Violence Protocol, strangulation as defined by "the external compression of the neck, including the airway and blood vessels, causing reduced air and blood flow to/from the brain.")</li> <li>• Fractures in a non-ambulatory child</li> <li>• Injuries/bruises to a non-mobile infant</li> </ul>	<p>Referral – When child currently has any of these injuries, they should receive <u>immediate medical care</u> if not already obtained. If you have questions, please call 858-966-8951 during business hours or by calling 858-576-1700 and asking the Operator to page the on-call Child Abuse Physician.</p>

## FORENSIC MEDICAL EXAMINATIONS CRITERIA (CONTINUED)

Allegations	Description	Level of Criteria Determination
<p><b>Physical Abuse:</b> Victims (Current Minor/Moderate Injury)</p> <ul style="list-style-type: none"> <li>• Any child under 4 years old</li> <li>• Developmentally delayed, non-verbal and/or non-ambulatory children</li> </ul>	<p>Minor/Moderate Injury includes:</p> <ul style="list-style-type: none"> <li>• Bruising to the torso (abdomen, buttocks, genitals, thighs), ears, neck, frenulum (oral injury), jawline, fleshy cheeks, eyelids or bruising in the whites of the eyes</li> </ul>	Referral
<p><b>Physical Abuse:</b> Victims, all ages (Current Minor/Moderate Injury)</p>	Patterned bruising to child of any age.	Referral
<p><b>Physical Abuse:</b> Victims, all ages (Previous Minor/Moderate Injury that has been Photodocumented)</p>	<p>Minor/Moderate Injury as defined above in Physical Abuse: Victims, all ages (Current Minor/Moderate Injury).</p>	Referral for Paper Consultation
<p><b>Physical Abuse:</b> Other Children in Household, all ages (Minor/Moderate Injury)</p>	Only necessary if injuries are present or suspected for those children	Discretionary/Consultation
<p><b>Severe Neglect:</b> Victims, all ages</p>	<ul style="list-style-type: none"> <li>• Concerns with caregivers causing failure to meet basic needs for food, shelter and/or supervision, resulting in serious injury and/or near fatal conditions and/or conditions if left untreated could cause serious impairment, injury or death.</li> <li>• Starvation</li> <li>• Malnutrition/Nonorganic Failure to Thrive (FTT)</li> <li>• Medical Neglect</li> <li>• Exposure to drugs, excluding in utero drug exposure</li> <li>• Supervisional Neglect – lack of oversight by a caregiver leading to injury as noted above</li> </ul>	Referral
<p><b>Severe Neglect:</b> Other Children in Household, all ages</p>	<ul style="list-style-type: none"> <li>• Starvation</li> <li>• Exposure to drugs, excluding voluntary intake by teenagers or in utero drug exposure</li> </ul>	Referral (only for categories defined in this row)
<p><b>Severe Neglect:</b> Other Children in Household, all ages</p>	<ul style="list-style-type: none"> <li>• Concerns with caregivers causing failure to meet basic needs for food, shelter and/or supervision, resulting in serious injury and/or near fatal conditions and/or conditions if left untreated could cause serious impairment, injury or death.</li> <li>• Malnutrition/Nonorganic Failure to Thrive (FTT)</li> <li>• Medical Neglect</li> <li>• Supervisional Neglect – lack of oversight by a caregiver leading to injury as noted above</li> </ul>	Discretionary/Consultation

Levels of criteria based on the allegations defined in the chart:

- **Referral:** Referrals will be made in order to offer to schedule a Medical Examination or Paper Consultation for children in the noted categories unless the investigating agency specifically determines a Medical Exam is not in the best interest of the investigation and/or the child. Investigators will follow the CAC-specific protocol for making a referral for an exam.
- **Discretionary/Consultation:** The investigating partner will consult with their Supervisor and/or other MDT partners (as needed, including the CAC) to determine if an exam is in the best interest of the child(ren) and investigation. If a decision is made that a Medical Examination is appropriate, a referral will be made. If clear concerns for an exam are not present, consider whether an exam is appropriate based on the child's previous trauma, developmental level and/or other factors. When there are differing opinions between agencies or additional questions, a consultation will be requested with the other MDT partners. Throughout the consultation process, the lead investigating agency will make the ultimate decision determining if an exam will be offered or not.



## FORENSIC MEDICAL EXAMINATIONS CRITERIA (CONTINUED)

When a medical consultation regarding a child is necessary, there are two options, a Forensic Medical Examination of the child and a Paper Consultation based on a review of existing investigative information and documentation. The chart below lists when each type of medical consultation should be sought. A Paper Consultation could result in the recommendation of an In Person Examination.

In Person Medical Examinations	Paper Consultations
<ul style="list-style-type: none"> <li>• As determined by review of the Child Abuse Pediatrician</li> <li>• Current injuries</li> <li>• Second opinion</li> </ul>	<ul style="list-style-type: none"> <li>• As determined by review of the Child Abuse Pediatrician</li> <li>• No current injuries</li> <li>• Second opinion – child previously seen by a medical professional who is not a Child Abuse Pediatrician</li> <li>• Medical record review for medical neglect determination</li> <li>• Medical record review for concerns of possible Medical Child Abuse (MCA)</li> <li>• Child fatality cases with concerns for possible abuse or neglect</li> </ul>

**In Person Medical Examinations:** Should a Social Worker need field consultation to determine if a child should be seen immediately in the Emergency Department (ED) or CAC (by availability), to consult on the timing and necessity for an In Person Medical Examination. The Social Worker may contact Chadwick Center for Children and Families, Rady Children’s Hospital – San Diego:

- Mondays – Fridays during regular business hours, please call 858-966-8951.
- For after-hours emergency consultation with a Child Abuse Pediatrician, please call the Rady Children’s Operator at 858-576-1700 and ask to speak to the Child Abuse Pediatrician on-call.

Typical reports are available within 2 weeks of In Person Medical Exams, although more complex cases can take longer.

**Paper Consultations:** Paper Consultations are not meant for urgent investigative needs or for children with current injuries. If the Investigator has an urgent request, the Chadwick Center Medical Team Social Worker (MTSW) should be contacted directly to determine next steps. The Investigator will request a Paper Consult through RedCAP (see *Appendix*). The Doctor of the Day will review the request and supporting documentation to determine if a paper consult is appropriate. Report time could be variable depending on clinical capacity and the nature of the request. Typical reports are available within 2 weeks, although extensive review of documentation for more complex cases can take longer.

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## ADVOCACY SERVICES

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Comprehensive, coordinated victim support and advocacy services are provided to children and families by several local agencies affiliated with the CACs and MDT through various funding streams. Support is available for all CAC clients throughout the life of the case, free of charge. Active outreach and follow-up support services for non-offending caregivers are also consistently available.

Advocates with specialized training provide a constellation of services including, but not limited to: crisis intervention, risk and general assessment, safety planning, support during and after interviews and/or medical exams, assistance in procuring services to meet basic needs, education on victims' rights and crime victims' compensation, provision of specialized referrals, transportation support, case/court updates, as well as court education and accompaniment, etc. Advocates also participate in Case Review and coordinated Case Management meetings to ensure continuity of care across programs.

Both the DA's Office Victim Assistance Program (VAP) Advocates and the City Attorney's Office (CAO) Victim Service Coordinators (VSC) offer comprehensive services to victims of all types of crimes. DA Victim Advocates and VSC assist all victims of crime regardless of age, background and/or immigration status. All services are free of charge. An Advocate can assist families even if a suspect is not identified or if criminal charges have not been filed. They provide crisis intervention, emergency assistance, resource and referral assistance, orientation to the criminal justice system, court support, case status information, notification of family and friends, employer notification, California Victim Compensation Board (CalVCB) application assistance, restitution information, creditor/employer intervention, crime prevention, temporary restraining order information, property return and Victim Information and Notification Everyday (VINE) referrals.

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## **THERAPEUTIC INTERVENTION**

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Depending on the specific and individualized needs of the child and family, it is recommended that there is a continuum of care of therapeutic interventions that are available to meet their unique needs. These range from crisis intervention services and short-term therapy to long-term trauma-focused treatment services for both the child and the non-offending caregiver (NOC). Therapy services are available to all CAC clients, regardless of funding. Multiple types of funding sources exist specifically to support victims of child abuse and neglect, including Victims of Crime Act (VOCA) funding through the California Office of Emergency Services (Cal-OES), as well as California Victims Compensation Board (CalVCB) Victims of Crime (VOC) funding and other grants.

### **Crisis Intervention**

Following disclosure of abuse or neglect, the child and/or caregiver may be experiencing multiple emotions and crises, including managing the disclosure itself, as well as other types of relational challenges. An important part of crisis intervention includes screening for high-risk behaviors, including harm to self or others and assessing safety risk for domestic violence. A trained mental health provider can provide crisis intervention support and psychoeducation regarding the normal responses following the disclosure of abuse, the role of the CAC in supporting family's well-being, as well as other types of crisis supports.

### **Short-Term Therapeutic Intervention**

Following the disclosure of abuse or neglect during a Forensic Interview and/or a Medical Exam, short-term therapeutic approaches can assist in normalizing the child and caregiver's experiences, as well as any feelings that may emerge. For example, one commonly used short-term trauma-focused intervention specifically designed for use in CACs is the Child and Family Traumatic Stress Intervention (CFTSI). CFTSI is a brief early intervention model for children and adolescents ages 7-18 that is implemented soon after exposure to a potentially traumatic event or in the wake of disclosure of physical and/or sexual abuse. CFTSI fills a gap between acute responses/crisis intervention and evidence-based, longer-term treatments designed to address traumatic stress symptoms and disorders that have become established. The goal of this family-strengthening model is to improve the caregiver's ability to respond to, and support, a child who has endorsed at least one posttraumatic symptom. By raising awareness of the child's symptoms, increasing communication and providing skills to help master trauma reactions, CFTSI aims to reduce symptoms and prevent onset of post-traumatic stress disorder (PTSD). In addition, CFTSI offers an opportunity to assess which children and families need longer-term treatment.

### **Long-Term Therapeutic Intervention – Trauma-Informed Mental Health Assessment**

The first step in longer term trauma-focused treatment services is for the child who has experienced trauma to be assessed by a mental health provider who has been trained specifically on treating trauma to determine if they are in need of trauma-focused therapeutic

services. The assessment protocol should include the use multiple informants and multiple types of data collection, including the following elements to individualize treatment planning:

- A clinical interview of the child
- Interview of parents and other caregivers
- A complete developmental, medical and family history
- A comprehensive trauma history
- Use of standardized assessment measures to explore problematic behaviors and trauma symptoms
- Behavioral observations of the child and family

Children who display posttraumatic symptoms should be referred for evidence-based or evidence-informed trauma-focused treatment.

### **Evidence-Based/Evidence-Informed Therapy Services**

Children of all ages who have experienced trauma can benefit from evidence-based or evidence-informed therapy services. Therapy services should promote healing and not be forensic in nature. Children should receive the most effective therapy available to treat their specific symptoms. The Therapist should be specially trained in evidence-based or evidence-informed treatment (see the [California Evidence-Based Clearinghouse for Child Welfare \(CEBC\) website](#)) for child abuse victims. CWS clients must be seen by Treatment and Evaluation Resources Management (TERM) providers. While there are multiple trauma-focused treatments available, many of them have similar core components. These include the following:

- Engagement/addressing barriers to service-seeking (to ensure clients receive an adequate dosage of treatment in order to make sufficient therapeutic gains)
- Psychoeducation about trauma reminders and loss reminders (to strengthen coping skills)
- Psychoeducation about posttraumatic stress reactions and grief reactions (to strengthen coping skills)
- Teaching emotional regulation skills (to strengthen coping skills)
- Maintaining adaptive routines (to promote positive adjustment at home and at school)
- Parenting skills and behavior management (to improve parent-child relationships and to improve child behavior)
- Constructing a trauma narrative (to reduce posttraumatic stress reactions)
- Teaching safety skills (to promote safety)
- Advocacy on behalf of the client (to improve client support and functioning at home, in school, in the juvenile justice system, etc.)
- Teaching relapse prevention skills (to maintain treatment gains over time)
- Monitoring client progress/response during treatment (to detect and correct insufficient therapeutic gains in timely ways)
- Evaluating treatment effectiveness (to ensure that treatment produces changes that matter to clients and other stakeholders, such as the court system)

Some of the commonly used and well-researched evidence-based treatments include:

- Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)
- Parent-Child Interaction Therapy (PCIT)
- Alternatives for Families: A Cognitive-Behavioral Therapy (AF-CBT)
- Eye Movement Desensitization and Reprocessing (EMDR)
- Child-Parent Psychotherapy (CPP)

Therapists may also integrate evidence-informed approaches, including the Assessment-Based Treatment for Traumatized Children: A Trauma Assessment Pathway (TAP) model.

### **Caregiver Therapeutic Services**

Support from parents and/or caregivers is the most important predictor of the child's ability to make a successful recovery from the trauma. Services to parents/caregivers (i.e., relatives, foster parents, adoptive parents, etc.), who may themselves be trauma survivors and whose interactions with the Investigators and helping professionals may be influenced by their own trauma history and posttraumatic stress reactions, should be arranged and coordinated so they are best able to support and protect the child(ren). Some commonly used therapeutic treatments for adults include:

- Cognitive Processing Therapy (CPT)
- Acceptance and Commitment Therapy (ACT)

### **Additional Mental Health Activities**

In addition to providing support with the activities provided previously, Mental Health Clinicians engage in additional supportive activities, including referral to other community services, regular participation on the MDT Case Review, serving as a Clinical Consultant and supporting the MDT in monitoring treatment progress and outcomes. Clinicians also participate in ongoing training, clinical supervision/consultation per NCA requirements.

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## LEGAL REPRESENTATION

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### **County Counsel**

County Counsel represents CWS in all juvenile dependency matters beginning with the filing of the petition to bring the case before the court pursuant to Section 300 of the WIC. This representation includes negotiating settlements and appearing in all juvenile dependency hearings, including at the trial and appellate courts, on behalf of the CWS Social Workers. As the attorney for the petitioner (CWS), County Counsel is responsible for the preparation and examination of witnesses, including experts and victims in juvenile dependency trials. County Counsel also provides ongoing legal advice and training on juvenile dependency issues for CWS.

### **District Attorney (DA)'s Office**

All felony child abuse cases involving victims currently under the age of 14 years old are prosecutable through the DA's Family Protection Division. Misdemeanor child abuse cases occurring outside the City of San Diego are vertically prosecuted by the Family Protection Division's branch units. Felony sexual abuse cases involving victims presently 14 years old or older and all human trafficking cases are referred to Sex Crimes and Human Trafficking Division. Juvenile perpetrator abuse cases (perpetrator of abuse or human trafficking under the age of 18 years old at time of the abuse or offense) are handled by the Juvenile Division. In both felony and misdemeanor cases, the Prosecutors and DA Advocates strive to minimize further trauma to the child victim/witness while promoting public safety.

### **City Attorney's Office (CAO)**

The City Attorney is responsible for the prosecution of all misdemeanor crimes occurring within the City of San Diego (excluding South Bay) and the City of Poway. All misdemeanor child abuse cases, including children left in cars, contributing to delinquency of children, child endangerment, exposure to domestic violence (DV) and Driving Under the Influence (DUI) with a child(ren) in the car, as well as child molest cases, are vertically prosecuted by the Domestic Violence and Sex Crimes Unit. The assigned Deputy City Attorney, along with a Victim Services Coordinator (VSC), will keep the victim and supporting adult family members informed of the legal process throughout the criminal proceedings and offer support and referral services. The CAO regularly utilizes expert witnesses, including medical personnel, to prove criminal cases.

### **Supporting a Family through the Legal Process**

The support a child victim receives through the legal process can have a positive impact on the child's recovery. The Kids and Teens in Court (KTIC) Program through Chadwick Center is available to child and teen victims and witnesses who may need to testify in criminal or juvenile court. The program provides:

- Psychoeducation to caregivers
- Desensitization to the courtroom for children and adolescents

- Relaxation and other techniques for reducing anxiety in the courtroom for children and adolescents
- Information regarding the roles of courtroom personnel
- If a child is expected to testify in court, the CWS SW and/or other provider will coordinate to refer the child to KTIC.

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## SPECIAL POPULATIONS

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### Identifying Special Populations

The CACs and MDT partner agencies understand the importance of providing inclusive screening and assessment to identify special populations. Special population considerations are discussed with the MDT for the most appropriate referral and connection to local resources.

### Children Exposed to Violence

Children may overhear/witness domestic violence (DV) or could be a direct victim if they were threatened, battered or injured, either directly or indirectly. California has implemented laws protecting children involved in DV incidents (see P.C. 273a(a) or P.C. 273a(b) among other charges).

#### **Assessing a Child's Involvement as a Witness and/or Victim**

Children of most ages are often able to describe a violent episode. In order to obtain the most accurate information, all children present should be interviewed separately, with special attention to the child's demeanor. These important observations assist Prosecutors in determining whether the statement will be admissible in court. Color photographs of the crime scene and evidence can corroborate the child's statement and/or demonstrate the child's exposure to violence.

Investigators should refer back to their agency policy, as well as the *San Diego County Domestic Violence Protocol* for further guidance. Additionally, the San Diego Domestic Violence Council (SDDVC) is a network of local organizations collaborating to develop "an enhanced system-wide structure and response to domestic violence" that supports and addresses the needs in San Diego County. Based on danger and lethality assessments, families may also be referred to the High Risk Response Team (HRT) for more intensive support. The San Diego Humane Society and Rancho Coastal Humane Society can also provide support to families' pets impacted by DV.

#### **Forensic Interviews for Children Exposed to Serious Crimes**

When a DV incident involves serious charges, such as attempted murder or murder, all children living in the home should be interviewed as soon as possible by a trained Forensic Interviewer at Chadwick Center or Palomar Health.

Children who are critical witnesses to other violent or serious felonies should also be considered for Forensic Interviews.



## **Intimate Partner Violence (IPV)/Teen Dating Violence**

Palomar Health Forensic Health Services' trained Forensic Nurse Examiners (FNEs) and Chadwick Center's Child Abuse Pediatricians will perform Forensic Medical Examinations for the purposes of documenting injuries sustained during a violent intimate partner assault, including strangulation.

California Family Code (FC) 6930 seeks to ensure that minors between the ages of 12 and 17 years old have the ability to consent to obtain medical care related to the diagnosis, treatment and collection of medical evidence with regard to the crime of "intimate partner violence." FC 6930 defines intimate partner violence (IPV) for minors as "an intentional or reckless infliction of bodily harm that is perpetrated by a person with whom the minor has or has had a sexual, dating or spousal relationship."

Please refer to the *San Diego County Healthcare Standards for Intimate Partner Violence*, developed by the Healthcare Committee of the San Diego Domestic Violence Council (SDDVC) for further guidelines. Additional information can be located on the [San Diego County Health CARES \(Conduct screening, Assess, Report, Evaluate, Safety plan\) website](#).

## **Tribal**

San Diego County has 18 Native American Reservations, representing 4 tribal groups, which is more than any other county in the United States. Tribal members often experience higher levels of DV and sexual assault. They also experience unique and challenging barriers such as historical trauma and fear of losing children, isolation, lack of resources, inadequate medical care, living with or near a perpetrator's family or reservation, etc. Connections to tribal resources is extremely important and may include, but are not limited to: Indian and Southern Indian Health Councils, Inc., Peace Between Partners (PBP), CWS support with Indian Child Welfare Act (ICWA), Tribal Family Services, California Indian Legal Services, Strong Hearted Native Women's Coalition, Inc., Southern California American Indian Resource Center, etc.

## **Commercial Sexual Exploitation of Children (CSEC)**

Collaboration and coordination among agencies is important to improve the capacity to identify commercial sexual exploitation of children (CSEC) victims, as well as provide safety and trauma-informed services for them and their families. CSEC victims rarely identify as victims and/or may be fearful of retaliation. Language plays a significant role in the success of interactions and interventions. Identifying these children/youth as victims and survivors, as opposed to criminals, can help change how they are viewed in the community. It also validates their trauma and exploitation.

The San Diego Regional Human Trafficking (HT)/CSEC Advisory Council and its subcommittees are leading local initiatives. For more information, refer to the *CSEC Interagency Protocol* located on the [Superior Court of California – County of San Diego website](#), which also details other supportive services.

## **Youth with Problematic Sexual Behaviors (YPSB)**

Collaboration and coordination among agencies improves outcomes by better assessing risk and protective factors to determine the appropriate level of response for youth with problematic sexual behaviors (YPSB) cases. Effective interventions include thorough safety assessments, coordinated case management and family-centered support. Specialized treatment focuses on the behavior and separates the behavior from the child, with special attention to language and labels. Local resources may include, but are not limited to: CAC support and consultation, STEPS, Military Family Advocacy Programs (FAPs), etc.

## **Disability and Special Needs**

Children and youth with disabilities or special needs are at increased risk for abuse. Local resources may include, but are not limited to: Rady Children's Hospital – San Diego specialty clinics (Developmental Evaluation Clinic (DEC), Developmental Screening and Enhancement Program (DSEP), Developmental Services, Developmental-Behavioral Pediatrics, Down Syndrome Center, Autism Discovery Institute, Center for Gender-Affirming Care, Cochlear Implant Program, Healthy Development Services (HDS), etc.), San Diego Regional Center (SDRC) and Victim Assistance and Support Team (VAST), Deaf Community Services (DCS), Autism Society San Diego, SEEDS Therapy Center, etc.

## **LGBTQIA+**

Youth that identify as lesbian, gay, bisexual, transgender, queer and/or questioning, intersex, asexual and/or ally (LGBTQIA+) may experience negative attitudes that put them at increased risk for violence and other health-related disparities. Local LGBTQIA+ resources may include, but are not limited to: North County LGBTQ Resource Center, San Diego County LGBTQ Community Center, Rady Children's Hospital – San Diego Center for Gender-Affirming Care, etc.

## **Military and Veteran**

San Diego has some of the largest military and veteran populations in the nation. The military installations in San Diego include: Marine Corps Air Station Miramar, Marine Corps Base Camp Pendleton, Marine Corps Recruit Depot San Diego, Naval Base San Diego, Naval Base Coronado, Naval Base Point Loma and US Coast Guard Station San Diego. Collaboration between Family Advocacy Programs (FAPs) and MDT partners is essential to providing appropriate services and supports to military personnel and their families to ensure necessary prevention services, victim safety, offender accountability, rehabilitation and treatment, as well as military accountability and oversight. Other military and veteran services may include, but are not limited to: VA San Diego Healthcare System (VASDHS), Naval Medical Center and Balboa Naval Medical Center, Armed Services YMCA, Courage to Call, Fleet and Family Support Center, Military One Source, etc.

## Homeless

San Diego County has one of the largest homeless populations in the nation, with the vast majority becoming homeless while living here. The County of San Diego Health and Human Services Agency (HHS) and San Diego 2-1-1 keep a comprehensive listing of emergency shelter and transitional housing contacts, as well as support for hotel/motel vouchers, rapid rehousing, rental assistance and safe parking programs.

The San Diego Shelter Support Services Committee (SSSC) is a network of local organizations collaborating to support and provide resources for those struggling with homelessness and other co-occurring issues around San Diego County. This includes the San Diego Humane Society and Rancho Coastal Humane Society, who may also be able to provide support/resources to families' pets impacted by homelessness. Additionally, the Southern California (SoCal) Safe Shelter Collaborative rapidly connects survivors of human trafficking, DV and sexual assault to safe shelter utilizing a robust online system to minimize barriers and delays, while emphasizing a warm handoff across providers.

## Immigrant and Refugee

San Diego County is home to a large immigrant population based on its proximity to Mexico, as well as a large and diverse refugee population. Given their legal status, it may be difficult for these populations to obtain support and resources that US citizens have access to. There may also be a fear of retaliation or deportation, which puts immigrants and refugees at increased risk for trauma, abuse, assault and trafficking.

Immigration services can help provide assistance with green cards, immigration documents, citizenship/naturalization classes and petitioning for family members, mental health services, etc. Local immigration resources may include, but are not limited to: Office of Immigrant and Refugee Affairs, American Civil Liberties Union (ACLU) of San Diego & Imperial Counties, Casa Cornelia, Employee Rights Center, Immigration Center for Women and Children, Jewish Family Services, San Diego Legal Aid Society, San Diego Volunteer Lawyers Program, University of San Diego (USD) Free Legal Assistance, Catholic Charities, License to Freedom, Nile Sisters, etc.

Resettlement services can help a family with housing, acculturation, health care navigation, continuing education, access to public services, English as a Second Language (ESL) enrollment, employment services and financial literacy. Local refugee resources may include, but are not limited to: Office of Immigrant and Refugee Affairs, Jewish Family Services, International Rescue Committees (IRC), San Diego Refugee Forum, Catholic Charities, Alliance for African Assistance, Survivors of Torture International, License to Freedom, etc.

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## CASE REVIEW MEETINGS

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Case Review is a formal process through which primary and ancillary MDT professionals come together to discuss cases, to include facts and observations, that help inform the investigative and protective decision-making process, discuss the status of active child abuse and neglect cases, track criminal and civil matters and coordinate appropriate interagency collaboration. Likewise, MDT Case Review provides a forum for cross-discipline training/education.

MDT cases are primarily identified for review by mandated reports throughout RCHSD, Chadwick Center and Palomar Health, as well as active cases with other MDT partners. Cases may be prioritized by those that include, but are not limited to: death due to non-accidental trauma; serious injuries or inpatient hospitalizations; serious sexual abuse or STIs; chronic or high risk Medical Child Abuse (MCA) or neglect; cases involving infants/toddlers; an immediate safety threat within a child's home or concerns of trafficking; repeat or multiple victim/perpetrators; developmental delays or disabilities; possible delays or gaps in services; differing opinions on mechanisms of injury or numerous risk factors; etc.

Any MDT agency is able to request a case be put on the agenda for Case Review and/or follow up. This request can be made to the CAC Coordinator and should include the following information: child's name, date of birth, purpose of review/type of abuse, Law Enforcement jurisdiction, assigned detective and CWS SW if known. The CAC Coordinator will prioritize cases as appropriate based on time and needs.

- Chadwick Center Child Protection Team (CPT) Case Review: The CPT meets weekly on Wednesdays from 10am-12pm at Chadwick Center and/or Zoom and is facilitated by County Counsel. Draft agendas are distributed to the listserv by Friday afternoons and final agendas are distributed by Monday afternoons. Non-RCHSD employees will need to click on and follow instructions to set up a password to access the encrypted information.
- Palomar Health Child Abuse Program (CAP) Case Review: CAP meets on the fourth Tuesday of every month from 12-1:30pm at Palomar Health or virtual platform. The meeting agenda typically includes every case that has been seen at Palomar Health CAC the previous month.

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## CASE TRACKING, PROGRAM DEVELOPMENT AND PROGRAM EVALUATION

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### **Case Tracking**

Multidisciplinary team agencies agree to partner in collecting case tracking information throughout the life of the CAC case, beginning at onset through final disposition as outlined by [National Children's Alliance \(NCA\)](#) statistical/outcome data requirements. Purpose of such data collection is measuring MDT outcomes, areas of success and areas for continued improvement. Data collection is a joint effort, however Chadwick Center and/or Palomar Health will be responsible for storing the case-specific information and/or aggregate data and making it available to all MDT partners at their written request, as well as making it part of the ongoing discussion amongst CPT Management team for optimal program outcomes and improvement.

### **Program Development and Training**

CAC staff, to include Forensic Interviewers, Advocates, Medical Providers and Mental Health Clinicians will meet initial specialized training, ongoing education and other discipline-specific requirements as set forth by NCA's Standards for Accredited Members.

The MDT partners agree to cross-training and collaboration to ensure professional and program development across systems. Special attention will be focused on onboarding new MDT staff, providing secondary traumatic stress (STS) resources and ensuring appropriate linkages to new and existing community support services. Training new and current MDT members on the *San Diego County Child Victim-Witness Protocol* is done at the discretion of each participating agency, with support from the CACs as requested who will be responsible for developing and providing ongoing training to MDT agencies as implementation occurs county-wide.

### **Program Evaluation and Quality Improvement**

Program evaluation and quality improvement efforts are managed through the interagency CPT Management Team, with consultation regarding NCA's Outcome Measurement System (OMS) MDT Surveys results. There is a county-wide commitment by all agencies to regularly evaluate and amend this protocol in alignment with NCA requirements and county needs. Furthermore, any staffing or leadership changes will not impact implementation as the expectation is that each agency will ensure a warm handoff to continue the collaboration across systems. Ongoing and consistent communication to improve collaboration and service delivery will occur at a minimum of bi-monthly CPT Management meetings to ensure accountability, but more frequently as needed to establish goals, discuss demographics, examine trends, review statistical data, discuss service expansion and/or issues, reallocating resources, budgeting items, etc.

# APPENDICIES

## Minimal Facts Checklist

### SAN DIEGO COUNTY CHILD PROTECTION TEAM (CPT)

The best practice and standard of care is that children who have witnessed or been victims of trauma or abuse receive a Forensic Interview (FI). The goal is to have them speak about what happened only 1 time to a Forensic Interviewer.

First Responders determine probable cause and whether a crime may have occurred, identifying immediate protective actions and deciding whether a FI and/or Medical Exam will be needed.

If the First Responder is unsure whether a case meets Case Referral Criteria in the Victim-Witness Protocol chart, a Minimal Facts Interview (MFI) should be conducted. When the information needed for the MFI can be obtained from credible evidence, the First Responder should document that information and avoid a field interview of the child.

### WHEN SHOULD A MINIMAL FACTS INTERVIEW (MFI) BE DONE?

#### FI Criteria:

- Sexual Abuse
- CSEC
- Physical Abuse
- Severe Neglect
- Witness to violence
- Anyone with developmental delays

- In situations when it is necessary for LE to gather information directly from a child who will be referred for a FI, one designated person should be chosen to conduct a MFI and seek only enough information to make immediate protective/investigative decisions.
- CWS will gather information from all parties. Interviews of child victims should seek only enough information to make immediate protective/investigative decisions for all types of abuse and neglect. (The only exception to this is when an FI can be scheduled immediately and the CWS SW can conduct the child interview on other abuse types following the FI.)

**STOP** What language is child most comfortable speaking?

### WHAT DO YOU NEED TO KNOW?

#### Minimal Facts Field Interview:

(in home, school or other location)

- What happened (basic details only)?
- Who did it (suspect)? Who saw or knew?
- Where did it happen (jurisdiction)?
- When was the last incident/contact? (Forensic Medical Exam guidelines)
- Is child physically and emotionally safe? Who else may be a victim?

### AGENCY CONTACTS

For assistance with a case, immediately contact a Supervisor or your agency's Investigations Unit.

Name:  
Phone # :  
Name:  
Phone #:

### WHERE SHOULD MINIMAL FACTS INTERVIEW TAKE PLACE?

#### Considerations for a child victim-centered approach:

#### Minimize trauma and number of interviews

- When possible, conduct interview in a neutral, child-friendly environment, away from where the abuse occurred to help the child feel safe and minimize distractions
- Conduct interviews away from alleged suspect, witnesses and parents/guardians
- If interview is conducted at school, ask the child if they would like a support person/advocate present
- Refer to your department-specific guidelines for additional information

### HOW TO QUESTION A CHILD

**DO** build rapport with child, express interest in them as a person, not just as victim/witness.

**DO** remain neutral, objective and supportive.

**DO** use the child's words and document child's statement as accurately as possible.

**DO** ask for basic details to make immediate protective/investigative decisions.

**DO NOT** introduce new information (words, sexual acts, concepts, etc.) through words or actions. **DO NOT** summarize or paraphrase.

**DO NOT** ask "yes/no" or "why" questions.

**DO NOT** ask questions related to time such as "How many times?", "What time?" or "How long?"

**DO NOT** react to child's statements in ways that may minimize, blame, frighten, shame the child victim/witness or make assumptions about child's perception of the alleged abuse, incident or suspect.

Use Narrative Prompts and Open Ended Questions as much as possible:

#### Examples:

- Tell me what I came to talk to you about.
- What happened?
- When was the last time that \_\_\_\_\_ happened?
- Who did \_\_\_\_\_ to you?
- Where were you when \_\_\_\_\_?

**DO NOT** introduce new information to the child.

Listen and use the child's own words.

### WHAT NEXT

Before leaving the scene...

Adults should be reminded not to discuss the case in the child's presence or question the child further about the allegations. Caretakers should be encouraged to support and believe the child, listen if the child wants to talk and later document what the child shares. Provide information about next steps as appropriate.

*\*Forensic Interviews and Medical Exams are scheduled and conducted at the Children's Advocacy Centers (CACs): Chadwick Center at Rady Children's Hospital—San Diego or Palomar Health Forensic Health Services in North County.*



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## CHADWICK CENTER – FORENSIC INTERVIEW REFERRAL FORM

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CPT members can call 858-966-8951 to schedule an appointment.

To refer for a NON-urgent Forensic Interview, you can complete the [online form](#) at [redcap.rchsd.org/surveys/?s=YDDLHEXFXD](https://redcap.rchsd.org/surveys/?s=YDDLHEXFXD) (passphrase is *chadwick (all lowercase)*) or scan the QR Code instead of calling. The online form is also used to request Paper Consultations.

Please have the following information available for all referrals: Victim's name and date of birth (DOB), type of abuse, brief synopsis of allegations, who the child has disclosed to, suspect information, preferred languages, developmental/disability information, caregiver and family information, scheduling availability, etc.



A  
+



### Chadwick Forensic Interview Referral Form

Please use this form to request forensic interviews at the Chadwick Center. This form should not be used for immediate needs - i.e. interviews for today or tomorrow. Instead, please call us at 858-966-8951 to schedule.

**FOR SAME DAY OR NEXT DAY INTERVIEWS AND/OR SART EXAMS, DO NOT USE THIS REFERRAL FORM.  
CONTACT CHADWICK AT 858-966-8951.**

**Requested by**

\* must provide value

**Do you have a Vidanyx account?**

Yes

No

**Vidanyx is the electronic storage for interviews and you must have an account in order to view the interview.**

reset

**If no, you will be taken to an additional page to provide the necessary information for Chadwick to create an account for you.**

\* must provide value

**Alleged Victim/Witness Information (use all the same fields even if the child to be interviewed is a witness)**

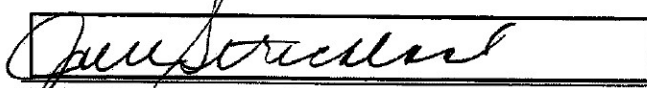
\*This page is for reference only and is subject to change.





# CHILD VICTIM-WITNESS PROTOCOL SIGNATURE PAGE

"Our attached signatures signify our commitment to the goals of the San Diego County Child Victim-Witness Protocol."



**Jill Strickland, Senior Vice President and Chief Administrative Officer,  
Rady Children's Hospital – San Diego (RCHSD)**

9/21/22

Date



**Lisa Conradi, Psy.D., Executive Director, Chadwick Center for  
Children & Families**  
*[CAC, Mental Health, Medical and Victim Advocacy]*

9/21/22

Date



**Diane L. Hansen, President and CEO of Palomar Health  
Palomar Health, a California local healthcare district**  
*[CAC, Mental Health, Medical and Victim Advocacy]*

9/29/22

Date



**Summer Stephan, District Attorney, San Diego County**

12-19-2022

Date

**Mara W. Elliott** Digitally signed by Mara W. Elliott  
Date: 2022.08.17 08:02:54 -07'00'

**Mara Elliott, San Diego City Attorney**

8/17/22

Date



**Claudia Silva, County Counsel, County of San Diego**

October 6, 2022

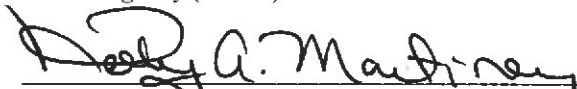
Date



**Nick Macchione, San Diego County Director of Health and Human  
Services Agency (HHSA)**

10-14-22

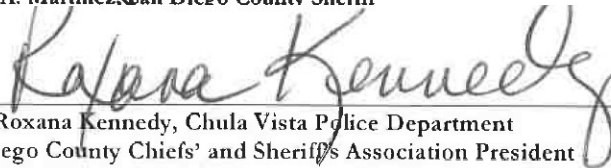
Date



**Kelly A. Martinez, San Diego County Sheriff**

11/13/23

Date



**Chief Roxana Kennedy, Chula Vista Police Department  
San Diego County Chiefs' and Sheriff's Association President**

9/7/2022

Date

On behalf of the following law enforcement agencies:

- Carlsbad Police Department
- California Highway Patrol
- Chula Vista Police Department
- Coronado Police Department
- El Cajon Police Department
- Escondido Police Department
- La Mesa Police Department
- National City Police Department
- Oceanside Police Department
- San Diego Harbor Police Department
- San Diego Police Department