

REPORTS OF CHILD ABUSE AND NEGLECT

January 31, 1991 – PT 91.2

// APPENDIX C: LIST OF REGIONAL PERINATAL CENTERS AND HOSPITALS THEY SERVE

// I. PERINATAL SYSTEM: UNIVERSITY OF CHICAGO

A. Perinatal System: University of Chicago Hospitals
5841 Maryland Avenue
Chicago, IL 60637

Neonatal Director: Kwang-Sun Lee, M.D. (312) 702-6682

//

<u>Community Hospital</u>	<u>City</u>	<u>County</u>
Little Company of Mary	Evergreen Park	Cook
South Suburban	Hazel Crest	Cook
Jackson Park Hosp and Medical Center	Chicago	Cook
South Chicago	Chicago	Cook
St. Bernard	Chicago	Cook
Ingalls Memorial	Harvey	Cook
St. Mary's	Kankakee	Kankakee
Riverside Medical Center	Kankakee	Kankakee
Mercy Hospital and Medical Center	Chicago	Cook
Central Community Hospital	Clifton	Iroquois
Louis A. Weiss Memorial	Chicago	Cook

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II. PERINATAL SYSTEM: COOK COUNTY HOSPITAL

A. Perinatal Center: Cook County Hospital
1825 West Harrison Street
Chicago, IL 60612

// Neonatal Director: Rosita Pildes, M.D. (312) 633-8638

<u>Community Hospital</u>	<u>City</u>	<u>County</u>
Augustana	Chicago	Cook
Roseland Community	Chicago	Cook
St. Anthony's	Chicago	Cook
Bethany Hospital	Chicago	Cook

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III. PERINATAL SYSTEM: NORTHWESTERN MEMORIAL HOSPITAL PRENTICE WOMEN'S HOSPITAL AND MATERNITY CENTER

A. Perinatal Center: Prentice Women's Hospital and Maternity Center
333 E. Superior St.
Chicago, IL 60611

// Neonatal Director: John J. Boehm, M.D. (312) 908-7514

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B. Sub Perinatal Center: Evanston Hospital
2650 Ridge Avenue
Evanston, IL 60201

Neonatal Director: Thomas Gardner, M.D. (312) 492-3902

C. Sub Perinatal Center: Children's Memorial Hospital
2300 Children's Plaza
Chicago, IL 60614

// Neonatal Director: Edward Ogata, M.D. (312) 880-4142

<u>Community Hospital</u>	<u>City</u>	<u>County</u>
St. Francis	Evanston	Cook
Columbus-Cueno	Chicago	Cook
Edgewater	Chicago	Cook
St. Francis Xavier Cabrini	Chicago	Cook
St. Mary of Nazareth	Chicago	Cook
Highland Park	Highland Park	Lake
Lake Forest	Lake Forest	Lake
Condell Memorial	Libertyville	Lake
Victory Memorial	Waukegan	Lake
St. Therese	Waukegan	Lake
U.S. Naval	Great Lakes	Lake
Good Shepherd	Barrington	Lake

IV. PERINATAL SYSTEM: UNIVERISTY OF ILLINOIS HOSPITAL

A. Perinatal Center: University of Illinois Hospital
1740 W. Taylor St.
Chicago, IL 60612

Neonatal Director: Dhampuri Vidyasagar, M.D. (312) 996-4818

B. Sub Perinatal Center: Lutheran General Hospital
1775 Dempster
Park Ridge, IL 60068

// Neonatal Director: Henry Mangurten, M.D. (312) 696-5313

C. Sub Perinatal Center: Michael Reese Hospital and Medical Center
2929 South Ellis Street
Chicago, IL 60616

Neonatal Director: David Fisher, M.D. (312) 791-4216

<u>Community Hospital</u>	<u>City</u>	<u>County</u>
MacNeal Memorial	Berwyn	Cook
Holy Family	Des Plaines	Cook
Humana Hospital	Hoffman Estates	Cook
Northwest Community	Arlington Heights	Cook

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Chicago College of Osteopathic Med	Chicago	Cook
Illinois Masonic Medical Center	Chicago	Cook
Ravenswood Hospital Medical Center	Chicago	Cook
St. Joseph	Chicago	Cook
John F. Kennedy Hospital	Chicago	Cook
Olympia Fields Osteopathic	Olympia Fields	Cook
Copley Memorial	Aurora	Kane
Mercy Center for Health Services	Aurora	Kane
Delnor Hospital	St. Charles	Kane
Norwegian American Hospital	Chicago	Cook

V. PERINATAL SYSTEM: LOYOLA UNIVERSITY - FOSTER G. MCGAW HOSPITAL

A. Perinatal Center: Foster G. McGaw Hospital of Loyola University
2160 South First Avenue
Maywood, IL 60153

// Neonatal Director: Craig Anderson, M.D. (708) 216-6964

	<u>Community Hospital</u>	<u>City</u>	<u>County</u>
//	LaGrange Memorial General	LaGrange	Cook
	Westlake Community	Melrose Park	Cook
	Gottlieb Memorial	Melrose Park	Cook
	Oak Park Hospital	Oak Park	Cook
	West Suburban	Oak Park	Cook
	Alexian Brothers	Elk Grove Vill	Cook
	Resurrection	Chicago	Cook
//	Elmhurst Memorial Hospital	Elmhurst	Cook
	Good Samaritan	Downers Grove	DuPage
	Central DuPage	Winfield	DuPage
//	Hinsdale Hospital	Hinsdale	DuPage
	Edward Hospital	Naperville	DuPage
//	Glenoaks Medical Center		

VI. PERINATAL SYSTEM: RUSH-PRESBYTERIAN-ST. LUKES MEDICAL CENTER

A. Perinatal Center: Rush-Presbyterian-St. Luke's Medical Center
1753 West Congress Parkway
Chicago, IL 60612

// Neonatal Director: Werner A. Meier, M.D. (312) 942-6611

B. Sub Perinatal Center: Christ Hospital
4440 West 95th Street
Oak Lawn, IL 60453

Neonatal Director: M. Rothi, M.D. (312) 425-8000

C. SubPerinatal Center: Mt. Sinai Hospital
California Ave at 15th Street
Chicago, IL 60608

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Neonatal Director: Pablo Arnecellia, M.D. (312) 650-6475

<u>Community Hospital</u>	<u>City</u>	<u>County</u>
St. Francis	Blue Island	Cook
St. James	Chicago Heights	Cook
Palos Community	Palos Heights	Cook
Swedish Covenant	Chicago	Cook
Grant	Chicago	Cook
Silver Cross	Joliet	Will
St. Joseph	Joliet	Will
Holy Cross Hospital	Chicago	Cook
// Rush North Shore	Skokie	Cook

VII. PERINATAL SYSTEM: ROCKFORD MEMORIAL HOSPITAL

A. Perinatal Center: Rockford Memorial Hospital
2400 North Rockton Avenue
Rockford, IL 61101

Neonatal Director: Lida Kechavarz, M.D. (815) 968-6861

<u>Community Hospital</u>	<u>City</u>	<u>County</u>
St. Joseph	Belvidere	Boone
Savanna City	Savanna	Carroll
Sandwich Community	Sandwich	DeKalb
Kishwaukee Community	DeKalb	DeKalb
St. Joseph	Elgin	Kane
Katherine Shaw Bethea	Dixon	Lee
Harvard Community Memorial	Harvard	McHenry
Memorial Hospital for McHenry County	Woodstock	McHenry
Rochelle Community	Rochelle	Ogle
Freeport Memorial	Freeport	Stephenson
Morrison Community	Morrison	Whiteside
Community General	Sterling	Whiteside
St. Anthony	Rockford	Winnebago
Swedish American	Rockford	Winnebago
Mendota Community	Mendota	Ottawa
Northern Illinois Medical Center	McHenry	McHenry
// Sherman Hospital	Elgin	Kane

VII. PERINATAL SYSTEM: ST. FRANCIS MEDICAL CENTER-PEORIA

A. Perinatal Center: St. Francis Medical Center
530 N.E. Glen Oak Avenue
Peoria, IL 61637

Neonatal Director: Tim Miller, M.D. (309) 655-2485

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<u>Community Hospital</u>	<u>City</u>	<u>County</u>
Perry Memorial	Princeton	Bureau
St. Margaret	Spring Valley	Bureau
// Carle Foundation and Covenant Medical Center -- Urbana Campus	Urbana	Champaign
Gibson Hospital Association	Gibson City	Ford
Graham Hospital Association	Canton	Fulton
Morris	Morris	Grundy
Memorial	Carthage	Hancock
Hammond-Henry District	Geneseo	Henry
Kewanee Public	Kewanee	Henry
Iroquois Memorial	Watseka	Iroquois
Galesburg Cottage	Galesburg	Knox
St. Mary's	Galesburg	Knox
// Community Hospital of Ottawa	Ottawa	LaSalle
Illinois Valley Community	Peru	LaSalle
St. Mary's	Streator	LaSalle
Fairbury	Fairbury	Livingston
St. James	Pontiac	Livingston
McDonough District	Macomb	McDonough
St. Joseph Hosp. Medical Center	Bloomington	McLean
Brokaw	Normal	McLean
Mercer County	Aledo	McLean
The Methodist Medical Ctr. of Ill.	Peoria	Peoria
Proctor Community	Peoria	Peoria
Moline Public	Moline	Rock Island
Franciscan	Rock Island	Rock Island
// Illini Hospital District	Silvis	Rock Island
Pekin Memorial	Pekin	Tazewell
Community Memorial	Monmouth	Warren
// Covenant Medical Center -- Champaign Campus		

IX. PERINATAL SYSTEM: ST. JOHN'S HOSPITAL-SPRINGFIELD

- A. Perinatal Center: St. John's Hospital
800 East Carpenter Street
Springfield, IL 62769
- Neonatal Director: Narinder Khanna, M.D. (217) 544-6464

<u>Community Hospital</u>	<u>City</u>	<u>County</u>
Blessing	Quincy	Adams
St. Mary's	Quincy	Adams
St. Vincent Memorial	Taylorville	Christian
Clay County Hospital	Flora	Clay
Sarah Bush Lincoln Health Ctr.	Mattoon	Coles
Crawford Memorial	Robinson	Crawford
Dr. John Warner	Clinton	DeWitt
Jarmen Memorial	Tuscola	Douglas

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	St. Anthony Memorial	Effingham	Effingham
	Lawrenceville County Memorial	Lawrenceville	Lawrence
	Jersey Community	Jerseyville	Logan
	Abraham Lincoln Memorial	Lincoln	Logan
	Decatur Memorial	Decatur	Macon
	St. Mary's	Decatur	Macon
//	Community Memorial	Staunton	Macoupin
	Hillsboro	Hillsboro	Montgomery
	St. Francis	Litchfield	Montgomery
	Passavant Memorial Area	Jacksonville	Morgan
	Illini Community	Pittsfield	Pike
	Richland Memorial	Olney	Richland
	Sarah D. Culbertson Memorial	Rushville	Schuyler
//	United Samaritans Medical Center --		
	Logan Campus		
//	Memorial Medical Center	Springfield	Sangamon

X. PERINATAL SYSTEM: ST. LOUIS AREA

- // A. Perinatal Center: Cardinal Glennon Memorial Hospital for Children
1465 South Grand Boulevard
St. Louis, Missouri 63104
- Neonatal Director: William Keenan, M.D. (314) 454-6148
- // B. Perinatal Center: St. Louis Children's Hospital
500 South Kingshighway Boulevard
St. Louis, Missouri 63110
- // Neonatal Director: Sessioni Cole, M.D. (314) 454-6148

	<u>Community Hospital</u>	<u>City</u>	<u>County</u>
	Alton Memorial	Alton	Madison
	St. Anthony's	Alton	Madison
	St. Joseph's	Alton	Madison
	St. Elizabeth's	Granite City	Madison
	Oliver Anderson	Maryville	Madison
	Wood River Township	Wood River	Madison
	St. Joseph's	Breese	Clinton
//	Memorial Hospital	Chester	Randolph
//	Memorial Hospital	Belleville	St. Clair
	Centreville Township	East St. Louis	St. Clair
	St. Elizabeth's	Belleville	St. Clair
	USAF Medical Center	Scott AFB	St. Clair
	Edward A. Utlaut Memorial	Greenville	Bond
	Washington County	Nashville	Washington
	St. Clement's	Red Bud	Randolph
	Sparta Community	Sparta	Randolph
	UMWA Union Hospital	West Frankfort	Franklin
	Memorial Hospital	Carbondale	Jackson
	St. Joseph's Memorial	Murphysboro	Jackson
	Good Samaritan Hospital	Mt. Vernon	Jefferson

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St. Mary's Hospital	Centralia	Marion
Marshall Browning Hospital	DuQuoin	Perry
Pinckneyville Community Hospital	Pinckneyville	Perry
Wabash General	Mt. Carmel	Wabash
Fairfield Memorial	Fairfield	Wayne
Herrin	Herrin	Williamson
Marion Memorial	Marion	Williamson

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APPENDIX D: CANTS 2 INVESTIGATION FINDING PROCEDURES FOR PERSONS WHOSE LICENSURE, CERTIFICATION OR EMPLOYMENT IS AFFECTED BY INDICATED REPORTS

This Appendix provides special handling of Final Finding Reports (FFRs) for perpetrators employed in licensed child care facilities, schools, state facilities, for state employees including DCFS employees, for professionals subject to licensure, certification or registration by the Illinois Department of Professional Regulation, and for teachers certified or registered with Illinois State Board of Education. These procedures have the effect of expediting the appeal process for those persons whose employment, licensure, registration, or certification may be affected by an indicated report.

1) Field Submittal of FFRs

All CANTS 2 FFRs (with investigative files attached for indicated reports) involving licensed child care facilities, schools, State facilities or State employees (other than DCFS employees) and professionals subject to licensure, certification or registration by the Department of Professional Regulation or teachers certified or registered with ISBE, shall be submitted to the DCP Appeals Coordinator at the State Central Register. All FFRs (with investigative files attached for indicated reports) involving DCFS employees shall be submitted to the Administrator of the State Central Register.

2) Preparation of File for Mailing

Upon receipt of the FFR and copy of the investigation for Indicated reports, the DCP Appeals Coordinator will take appropriate action to delete information from the copy of the investigative file which would identify the name of the reporter and the identity of others who cooperated in the investigation, in preparation for mailing this material to the indicated perpetrator(s).

// 3) Special Notification Letter

a) The DCP Appeals Coordinator will forward the CANTS 2 forms to the SCR Data Entry Unit. The forms shall be prioritized and data entered immediately upon receipt. As the CANTS 2 is being entered the Data Error/Denial process is automatically performed. Denials will be processed according to established procedures.

b) For indicated reports with no denials on child care facilities, schools, state facilities or state employees, including DCFS employees or professionals subject to licensure by the Department of Registration and Education or teachers certified or registered with ISBE, a special notification letter will automatically be generated for the perpetrator that explains the Department's finding and the appeal process. The letters will be sent via Certified Mail to the indicated perpetrator(s) with an enclosed copy of the investigative file with appropriate deletions.

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- // c) Upon completion of the data entry process, the Data Entry Supervisor will provide the Appeals Coordinator with a copy of the CANTS 2 form, and forward the original to for filing.
- d) The DCP Appeals Coordinator is responsible for sending a carbon copy of this notification letter to the local child protection Regional Manager for informational purposes only and to the District Superintendent.
- 4) For reports involving DCFS employees, the SCR Administrator shall notify the Office of Employee Services for possible disciplinary action.
- 5) SCR will notify the Department of Professional Regulation and the Illinois State Board of Education whenever a perpetrator of an indicated report is a professional licensed by the Department of Professional Regulation or a teacher certified by or registered with the Illinois State Board of Education. SCR will also notify the Department of Professional Regulation or the State Board of Education whenever the indicated perpetrator has filed an appeal of the finding.
- 6) Upon request, SCR will send a copy of the unedited DCFS investigative file of the indicated report to the regional School Superintendent, the Department of Professional Regulation or the Illinois State Board of Education.

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Section 300. APPENDIX E: BURGOS CONSENT DECREE

The Burgos Consent Decree requires that DCFS in its Cook and Aurora Regions provide services in Spanish to Hispanic clients whose primary language is Spanish. Hispanic is defined as any person of Puerto Rican, Mexican, Central, South American or other Hispanic origin. Although the Burgos Consent Decree only applies to the Department's Cook and Aurora regions, best practice indicates that the following procedures should be applied statewide whenever child abuse or neglect investigations involve persons of Hispanic origin.

a) Reports to SCR

Whenever an initial report of child abuse or neglect is received by the State Central Register, the report taker will attempt to determine whether the parents/children who are the subjects of the report are of Hispanic origin and/or Spanish speaking. This will be indicated on a SACWIS intake report.

b) Local Investigative Unit

If either parent is of Hispanic descent and they or the alleged victims are identified as primarily Spanish speaking by SCR, the supervisor of the receiving investigative unit shall assign the report to a bilingual Investigation Specialist. The bilingual Investigation Specialist must complete the **CFS 1000-1/CFS 1000-1S**, Hispanic Client Language Determination Form and have it signed by the parents during the first contact with the parents. The investigation will be conducted in the language determined on the **CFS 1000-1/CFS 1000-1S**. If a bilingual Investigation Specialist is not available, a non-Spanish speaking investigator may be assigned to initiate the investigation with the help of an interpreter. Interpreters that may be used include police officers, medical or school personnel, therapists and service workers. Subjects of the report and persons making the report may not be used as interpreters. The interpreter shall be informed that all information is confidential and is not to be disclosed. The name, title, location and telephone number of the interpreter or the telephonic interpretation service used shall be documented on a SACWIS contact note. Document translations, in-person and by telephone interpretation services can be obtained through the vendors listed below.

Telephone interpretation services can be obtained from Propio Language Services at 1-866-828-3280; use the DCFS 4 digit account #3871. For 3-way phone connections: Consult with the first person who answers the phone. They will place the 3-way call. The alternate interpreter number, 1-866-386-1284, may be used when the primary line cannot provide the requested language. Additional information such as language codes can be found by visiting the following page;

[http://dnet/Affirmative Action/Forms/3871 intruccion card Tele %20Language line.pdf](http://dnet/Affirmative Action/Forms/3871_intruccion_card_Tele_%20Language_line.pdf)

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Vendor:	Multilingual Connections LLC	
	Translation Services	Interpretation Services
Contact:	Jill Bishop	David Medrano
E-mail:	info@workforcelang.com	info@interprenet.net
Telephone:	773.292.5500	312.928-1188

Note: When a non-Spanish speaking investigator initiates the investigation with the assistance of an interpreter, the CFS 1000-1/CFS 1000-1S will be completed during the first contact with the parents with the assistance of the interpreter.

If the parents and the alleged victim who are of Hispanic descent are identified as primarily English speaking by SCR, the supervisor of the receiving investigative unit shall assign a bilingual Investigation Specialist, who will have the **CFS 1000-1/CFS 1000-1S** completed and signed by the parents. If a bilingual Investigation Specialist is not available, the receiving investigative unit will proceed to investigate the report as required by ANCRA to ensure the safety of the child. In this case the **CFS 1000-1/CFS 1000-1S** will be completed by a bilingual investigator within seven days of receipt of the report. The **CFS 1000-1/CFS 1000-1S** shall be placed in the case file.

The client's status as a limited/non-English speaking person shall be recorded in the SACWIS Person Management window for each family member. The SACWIS indicator for preferred language must be recorded on the SACWIS Person Management Basic Tab. When the preferred language recorded is not English, the Interpreter Needed indicator is also required. Workers receiving a new or transferred case should always review the preferred language window to determine the client's communication needs.

c) Protective Custody

If protective custody is taken and the placement of children in substitute care is required, a bilingual protective service investigator will attempt to complete the **CFS 1000-1/CFS 1000-1S** before the placement is made or prior to the court hearing for the adjudication of temporary custody. In addition, every effort will be made to place the child or children with foster parents who are able to communicate in Spanish.

d) Communication

All individual or general written communication to Spanish-speaking clients by DCFS workers or vendors must be in Spanish.

e) Non-Cooperation

If clients of Hispanic origin refuse to sign the **CFS 1000-1/CFS 1000-1S**, investigative staff may proceed with the investigation.

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Appendix F - Casework Responsibilities in Minimizing the Effects of Separation and Loss in Substitute Care

Introduction

Children taken into the care of the state child welfare system experience a variety of losses brought about by change. By entering substitute care, they experience such obvious losses as familial relationships, school and/or peer relationships, and their actual home settings. If they have experienced multiple placements, changing families or caregivers numerous times, they experience losses such as the loss of cultural bonds, family traditions or daily routines.

Many, if not most, of the changes in the lives of these children are thrust upon them; it is not in their power to alter the events and circumstances that deeply and permanently impact their lives. The initial separation of a child from the home of his/her parents or foster parents is at least anxiety-producing, and, at most, severely traumatic. For children who have been in multiple substitute placements, the effects of loss are profound and long-term.

Factors Affecting Child's Feelings of Anxiety and Loss

The extent to which children's lives are impacted by the separation from their caregiver(s), is dependent upon:

- the age(s) at which they experience the separation(s);
- the types of loss(es)/separation(s) they experienced;
- the circumstances around the loss(es)/separation(s);
- their responses to the loss(es)/separation(s); and
- the help and support they were given at the time.

Indicators of Separation Anxiety

Children may experience any or all of the following types of emotional and behavioral reactions brought about by separation from their families:

- depression (potentially leading to self-destructive and/or suicidal behavior);
- physical aggression towards others;
- an inability to form healthy attachments to adults, or have adults form attachments to them;
- emotional delays, such as problems developing self-esteem, being aware of their own feelings or the feelings of others, and/or developing consciences;
- intellectual delays, such as problems developing organized and logical thought processes;
- social delays, such as general problems in getting along with other adults and children; and/or,
- a range of physical developmental delays.

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Children's reactions to separation and loss multiply each time they experience this trauma. Emotional and behavioral responses such as those previously described may jeopardize current placements, and increase the probability of restrictive future placements. The possibility that these types of losses can so severely impact the current and future functioning of children makes it imperative that this is addressed in a supportive and therapeutic manner at all stages of the assessment and service planning processes.

What Workers Can Do

The Department's consistent attention to permanency planning is "...based on the premise that stability in living arrangements and continuity of relationships with parental figures promotes children's worth and development." The child welfare system must acknowledge the critical importance of separation and loss to a child's long-term protection and permanency and act to decrease the subsequent impact.

Because separation and loss, and the resulting separation anxiety and grief, occur at various times throughout placement, the child protection specialist should be aware of the impact of this dynamic during the initial intervention and placement processes; likewise, the child protection specialist and permanency worker should be aware of the impact of this dynamic upon initial placement and throughout the assessment and service planning processes, particularly for children who experience multiple placements. Department and Purchase of Service staff are expected to use the "**Guidelines for Minimizing the Effects of Separation and Loss in Substitute Care**", below, to prepare and assist with the adjustment of children that are placed.

Issues about the separation and loss children experience should be reviewed throughout the assessment process. The Guidelines shall be followed each time a child is placed in substitute care. These Guidelines apply to the initial substitute placement and any subsequent placement changes, such as when a child is moved from one foster home to another foster home, foster care to residential placement, etc.

If, at any time, the child protection specialist or permanency worker becomes aware of any unmet needs during the initial or a subsequent placement process the child protection specialist/permanency worker shall share that information with appropriate Department or POS agency staff who need to know.

GUIDELINES FOR MINIMIZING THE EFFECTS OF SEPARATION AND LOSS IN SUBSTITUTE CARE

CHILD'S NEEDS:

- Encourage the child to ask questions and express his/her feelings about the separation and placement.
- Help the child select a favorite possession(s) to take with him/her.

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- Encourage and help the child pack his/her own belongings.
- Reassure the child that he/she is safe.
- Explain to the child how to contact his/her parent(s) and siblings (including step-siblings when he/she has a positive relationship with the step-siblings).
- Talk to the child about contacting his/her friends.
- Ask the child about his/her needs during placement.

PLACEMENT:

When placing a sibling group, the child protection specialist shall document the reason for the placement selection in the investigation file. The placement selection criteria set out below are mandatory, and compliance shall be documented.

- Every effort should be made to place siblings together at the time they enter care and when placement changes are necessary. Priority shall be given to caregivers who can accept an entire sibling group. Child protection specialists shall comply with Rules and **Procedures 402, Licensing Standards for Foster Family Homes** and **Procedures 301.80, Unlicensed Relative Home Placements** when making placements of children in a foster home.

“Sibling” are children who have at least one parent in common. Adopted siblings and siblings in guardianship are still considered siblings if they were in DCFS care under Article II of the Juvenile Court Act immediately prior to the adoption or guardianship. Step-siblings may be considered “siblings” when the children enter into substitute care together and have a positive relationship. For placement purposes, step-siblings who enter care together shall be placed together initially, and placement shall be re-evaluated after the Integrated Assessment.

If a joint placement for all of the siblings cannot be located, every effort shall be made to select caregivers who will encourage and support frequent contact and visitation among the siblings. The child protection specialist or permanency worker shall ensure that the caregivers and each member of the sibling group entering placement have received the DCFS publication **CFS 105-95, *How to Connect With Your Brothers and Sisters***.

If siblings cannot be placed together (in accordance with **Rule 301.70**), every effort should be made to place the siblings in homes or programs that will encourage and support the sibling relationship.

Note: Placement of an add-on child with his/her sibling who has been adopted or in subsidized guardianship is a relative placement. The family home is not required to be licensed to accept immediate placement of this child! If the

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family's license has expired, they should be encouraged to apply for licensure after the add-on child has been placed.

For children who were in the guardianship of the Department, and were adopted, and are subsequently returned to the temporary custody or guardianship of the Department, a "relative" may include any person who would have qualified as a relative under this definition prior to the adoption. However, the worker and supervisor must determine that it would be in the best interests of the child to consider such person as a relative.

- Ensure that the placement process includes the least minimal disruption to the child's life.
- Attempt to place the child in physical proximity to her/his parents, school, community, etc., if in the best interests of the child.
- Make a diligent search for a substitute caregiver who can meet the child's individual needs, in accordance with **Procedures 301.60, Placement Selection Criteria**. Diligent search requirements for a joint placement are set out in **Rule 301.70, Sibling Placement** and **Procedures 301.70(c), Diligent Search Upon Initial Placement**.
- Give the child the **CFS 1050-70, Putting It All Together Youth Handbook** (for children 10 years of age and older).
- Carry out the placement process in the most confidential manner possible.
- Talk to the child about the reasons he/she was removed from his/ her home.
- Explain your role as the investigation specialist and the role of the foster parents/relative caregivers.
- Observe and respond to the child's reactions to the substitute caregiver(s).
- Convey the immediate needs of the child to the substitute caregiver, including the child's need to have frequent contact with his/her siblings if they are placed apart.

VISITATION:

- Talk to the child about his/her right to have contact and visitation with his/her parent(s) and sibling(s). The child protection specialist shall review **Procedures 301.220, Sibling Visitation** and **301.230, Contact Among Siblings Placed Apart** before making decisions limiting visitation or contact between siblings placed apart. If the child protection specialist disallows or limits visitation or contact, the decision shall be reviewed by the child protection supervisor and documented in the investigation record.

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- Involve the child in setting parameters for sibling visitation and contact. Make sure the child understands when and where the first visit will occur and how often the visits will take place.
- Explain to the child what may happen during a visit.
- Explain to the child where visits may take place.

CHILD'S RIGHTS:

- Explain to the child his/her right to have contact and visitation with his/her parents, relatives, and siblings.
- Explain to the child about the court proceedings.
- Explain to the child his/her legal rights.
- Explain to the child how to contact his/her attorney.
- Explain to the child what he/she should do if he/she has problems with his/her substitute caregiver(s).
- Explain to the child about the service appeal process.

CHILD'S CONTACT WITH THE DEPARTMENT:

- Explain the role of the Department to the child.
- Talk to the child about what he/she may already know about the Department.
- Talk to the child about the worker's role in the investigation, initial placement, and on-going casework processes.
- Explain to the child how to reach his/her permanency worker.

ASSESSMENT:

- Explain to the child that an initial health exam will occur within 24 hours of the placement.
- Explain to the child that an Integrated Assessment will occur within the first 45 days.
- Talk to the child about how the permanency worker and the Department/POS agency will work with his/her family.
- Talk with the child about the on-going assessment and service planning processes.

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SPECIAL NEEDS:

- Attend to any special needs that require immediate attention (for example, a child who has a specific disability, a pregnant or parenting teen, etc.)
- If the child has a hearing impairment or uses an alternative non-verbal communication method, use, or arrange for the use of, the alternative method.

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APPENDIX G – CHILD ENDANGERMENT RISK ASSESSMENT

a) Requirements for Use of the Child Endangerment Risk Assessment Protocol

The **Child Endangerment Risk Assessment Protocol (CERAP)** safety assessment is used within the larger protocols of CPI and CWS practice. It is a "life-of-the case" protocol designed to provide workers with a mechanism for quickly assessing the potential for moderate to severe harm immediately or in the near future and for taking quick action to protect children. Workers utilize the protocol to help focus their decision-making to determine whether a child is safe in their home environment and, if unsafe, deciding what measures or actions must be taken to ensure the safety of the child. Even if a child is not in the home, e.g., if a child victim is in a hospital, the CERAP safety assessment is to be based on the child's return home. The major steps that are required to apply the protocol include an assessment and analysis of the safety threats, the completion of the **CERAP** and implementation and monitoring of **the CFS 1441-A, Safety Plan**, when necessary. The **CFS 1441-A (Safety Plan)** is a carbonized form intended to be completed by the investigator or worker in the home with copies left with the primary caregiver and the person most responsible for carrying out the safety plan, if different than the child's primary caregiver.

Department staff and contracted private agency staff are required to utilize the Child Endangerment Risk Assessment Protocol (CERAP) at the specified time frames and at any other time when the worker believes that a child may be unsafe.

- 1) CERAP is a **familial assessment only**; it is **not** completed during the investigation of facility reports, i.e., investigations involving foster homes, residential facilities, schools, or day care facilities.
- 2) Any child safety threats identified as the result of the CERAP must be incorporated into the SACWIS Family Service Plan.

b) Definitions

"Severity of the Behavior/Condition" means the likely degree of harm involved children are subjected to by a behavior/condition that is the responsibility of a caregiver. This degree of harm can range from low to moderate to severe.

"Moderate to Severe Harm" means a serious threat of danger to a child's life or health, impairment to his or her physical or mental well-being, or disfigurement.

"Immediately or in the Near Future" means that an incident can occur now or in the very near future i.e., before the next time department or contracted child welfare staff see a child, if **no** protective action is taken to ensure the child's safety.

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“Child Vulnerability” means any characteristic, condition, or behavior affecting a child that substantially increases the child’s susceptibility to the dangerous behavior of a caregiver or a dangerous condition within the home.

“History” means any known or credibly alleged previous or on-going examples of an identified dangerous behavior/condition for which a caregiver is responsible.

“Mitigation” means family strengths or action taken by caregivers **on their own initiative** (i.e., not instigated by Department staff) that keeps children safe from identified safety threats.

“Paramour” means a current or ex-boyfriend or girlfriend who has been or may be or is in a care-taking role. The paramour may or may not be residing within the family unit. Paramour involved families may be identified at the time of intake, during a child abuse or neglect investigation or anytime during the life of an open service case.

Note: A putative father would fall under the definition of paramour.

“Prevention Services”(formerly **Child Welfare Intake Evaluation**) means non-investigatory services directed to preserving families where children remain in their home without a threat to their safety. Prevention services can take the form of providing families with neighborhood/community linkages and advocacy services on a voluntary/self referral basis. They also may include, but are not limited to, court ordered services such as assessments and visitation orders from Marriage and Dissolution court.

“Safe” means that, after considering all reasonably available information/evidence concerning the presence of each of the 16 potential safety threats, and taking into account the vulnerability of the child, and considering the caregiver(s)’s displayed ability/action to mitigate any identified threats, it is determined that a child in a household or in custodial care is not likely to be moderately or severely harmed immediately or in the near future.

“Safety Plan” means a voluntary, temporary, short-term plan designed to control serious and immediate threats to children’s safety as a result of an unsafe finding on the CERAP. Safety Plans can take a variety of forms and are developed with the input and voluntary consent of the children’s legal caregivers and other family members. Safety plans are typically short term environmental manipulations to ensure child safety; they are not interventions designed to change behaviors over the long term.

Note: Safety Plans are not completed during investigations of foster homes, residential facilities, schools or day care facilities. When there is a formal investigation in these facilities, and the alleged perpetrator is a household member or another person in the facility, children are then protected by the implementation a protective plan, per **Procedure 383**

The **CFS 1441-A (Safety Plan)** is a carbonized form intended to be completed by the investigator or worker in the home with copies left with the primary caregiver and the person most responsible for carrying out the safety plan, if different than the child’s primary caregiver.

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"**Unsafe**" means that, after considering all reasonably available information/evidence concerning the presence of each of the 16 potential safety threats, and taking into account the vulnerability of the child, and considering the caregiver(s)'s displayed ability/action to mitigate any identified threats, it is determined that a child in a household or in custodial care is likely to be moderately or severely harmed immediately or in the near future. In the event a child is considered Unsafe, a safety plan or protective custody **must** be implemented by the worker completing the CERAP, and approved by the supervisor.

c) **Safety Concepts**

The Child Endangerment Risk Assessment Protocol (CERAP) is a process whose purpose is to identify the likelihood of moderate to severe harm, i.e. safety threats, in the immediate future. When immediate risk to a child's safety is identified, the protocol requires that action be taken, such as the implementation of a safety plan or protective custody. Identified safety threats and the safety plan to control them must be documented in SACWIS and the **CFS 1441-A, Safety Plan**.

Safety threats are restricted to the essential criteria of immediacy and severity or potential degree of harm. Since risk allows a broader concept for evaluation of the family, safety threats are depicted within the broader meaning of risk. The purpose of the broader area of risk is not control, but rather to decrease the risk of future maltreatment and resolve problems that cause risk. Safety threats must be controlled and risk factors may be resolved or reduced.

The primary purpose of the CERAP is to immediately control the situation to prevent harm from occurring in the short-term. The primary purpose of risk assessment is to reduce or resolve the problems that lead to risk. Safety and risk both require intervention in order to prevent harm, however safety must always be assessed quickly, while risk may be assessed over a longer period of time.

Safety and risk are different in two important ways:

- 1) Time Element:
 - Safety considers danger of harm now or in the very near future.
 - Risk considers a longer-term threat, e.g. a child may be at risk months into the future.
- 2) Potential Degree or Severity of Harm:
 - Safety is concerned with the potential for moderate to severe harm.
 - Risk is concerned with the full range of severity of harm, i.e., from low to severe.

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d) Instructions for Completing the CERAP

1) Identifying Information:

Enter the case name, the date of the SCR report, agency name, region/team/office or region/site/field, date of current assessment, date of certification, the name and ID of the investigator or worker completing the assessment, and the SCR/CYCIS number, if applicable.

2) Milestones: When the Protocol Must Be Completed Within Each Specialty

Indicate the activity and the milestone in relation to which the CERAP is being completed as follows:

A) **Child Protection Investigation** The CERAP safety assessment must be conducted on the child's home environment, at a minimum, at the following case milestones:

- i) Within 24 hours after the investigator first sees the child.
- ii) Whenever evidence or circumstance suggests that a child's safety may be in jeopardy.
- iii) Every 5 working days following the determination that a child is **unsafe** and a safety plan is implemented. Such assessment must continue until either all children are assessed as being safe, the investigation is completed or all children assessed as unsafe are removed from the legal custody of their parents/caregivers and legal proceedings are being initiated in Juvenile Court. This assessment should be conducted considering the child's safety status as if there was no safety plan, (i.e., would the child be safe **without** the safety plan?).
- iv) At the conclusion of the formal investigation, unless temporary custody is granted or there is an open intact case or assigned caseworker. The safety of all children in the home, including alleged victims and non-involved children, must be assessed.

For any Safety Threat that was marked "Yes" on the previous CERAP that is marked as "No" on the current CERAP (indicating the Safety Threat no longer exists), the completing worker will provide an explanation in a contact note as to what changed in order to eliminate the Safety Threat.

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B) **Prevention Service (formerly Child Welfare Intake Evaluation)** CERAP safety assessments must be conducted on the child's home environment when the assigned worker makes contact with the family, at a minimum, at the following case milestones:

- i) Within 24 hours of seeing the children, but no later than 5 working days after assignment of a Prevention Services referral.
- ii) Before formally closing the Prevention Services referral, if the case is open for more than 30 calendar days
- iii) Whenever evidence or circumstances suggest that a child's safety may be in jeopardy.

If any safety threat is marked "Yes" on the CERAP safety assessment, the Prevention Services worker should call the State Central Register (SCR) hotline.

C) **Intact Family Services** CERAP safety assessments must be conducted on the child's home environment, at a minimum, at the following case milestones:

- i) Within 5 working days after initial case assignment and upon any and all subsequent case transfers. **Note:** If the child abuse/neglect investigation is pending at the time of case assignment, the Child Protection Service Worker remains responsible for CERAP safety assessment and safety planning until the investigation is complete. When the investigation is complete and approved, the assigned intact worker has 5 work days to complete a new CERAP;
- ii) Every 90 calendar days from the case opening date;
- iii) When evidence or circumstances suggest that a child's safety may be in jeopardy;
- iv) Every 5 working days following the determination that any child is **unsafe** and a safety plan is implemented. Such assessment must continue until either all children are assessed as being safe, the investigation is completed or all children assessed as unsafe are removed from the legal custody of their parents/caregivers and legal proceedings are being initiated in Juvenile Court. This assessment should be conducted as if there was no safety plan (i.e., would the child be safe **without** the safety plan?).

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- v) Within 5 calendar days of a supervisory approved case closure.

For any Safety Threat that was marked “Yes” on the previous CERAP that is marked as “No” on the current CERAP (indicating the Safety Threat no longer exists), the completing worker will provide an explanation in a contact note as to what changed in order to eliminate the Safety Threat.

- D) **Placement Cases** For cases with a reunification goal, CERAP safety assessments must be conducted considering children’s safety as if they are to be returned to the caregivers from whom they were removed. At a minimum, the safety of children placed in substitute care must be assessed at the following case milestones:

- i) Within 5 working days after a worker receives a new or transferred case, **when there are other children in the home of origin.**
- ii) Every 90 calendar days from the case opening date.
- iii) When considering the commencement of unsupervised visits in the home of the parent or guardian.
- iv) Within 24 hours prior to returning a child home.
- v) When a new child is added to a family with a child in care.
- vi) Within 5 working days after a child is returned home and every month thereafter until the family case is closed.
- vii) Whenever evidence or circumstances suggest that a child’s safety may be in jeopardy.

For any Safety Threat that was marked “Yes” on the previous CERAP that is marked as “No” on the current CERAP (indicating the Safety Threat no longer exists), the completing worker will provide an explanation in a contact note as to what changed in order to eliminate the Safety Threat.

- E) **Clarifications Regarding Who Is Included in the CERAP Safety Assessment:** At the initial CERAP safety assessment conducted during the child abuse and neglect investigation:

- All alleged child victims must be seen and, if verbal, interviewed out of the presence of the caregiver and alleged perpetrator.

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- All other children residing in the home must be seen prior to the conclusion of the formal investigation, and, if verbal, interviewed out of the presence of the caregiver and alleged perpetrator.
- Non-involved children who are present during the initial CERAP safety assessment are to be included in the assessment.
- All adult members of the household and anyone listed as a case member shall be included in the CERAP safety assessment, to consider what effects they have on the children's safety.

If a child, caregiver, paramour or member of the household has not been included in the assessment, list who they are and why they were not assessed. When one of these members is assessed and the assessment changes the results of the current assessment, a new CERAP safety assessment must be completed. If the assessment does not change, the worker shall indicate this by opening the "Reason not Assessed" drop down box in the Members tab and returning it to no selection made (blank). The supervisor shall approve the addition of the participant.

If any change in the safety status of any child has been identified at any time, a new CERAP safety assessment must be completed.

e) **STEPS FOR COMPLETING THE CHILD ENDANGERMENT RISK ASSESSMENT PROTOCOL**

Safety Threat Assessment

Safety threats are behaviors or conditions that may be associated with a child or children being in danger of moderate to severe harm immediately or in the near future. All children residing in the home are to be seen, and if verbal, interviewed out of the presence of the caregiver and alleged perpetrator, if possible. When completing the CERAP, consider the effect any adult or other member of the household could have on a child's safety. Identify the presence of each threat by checking "Yes" on the **CERAP**, which is defined as there is **"clear evidence or other cause for concern."**

The simple presence of any one of the below listed behaviors and/or conditions does not, in and of itself, mean that a child should be determined to be unsafe. When considering the listed behaviors and/or conditions, the following criteria must be considered when assessing the presence of a safety threat:

- 1) **Child Vulnerability:** Each safety threat must be considered from the perspective of the threat it poses for **the particular children involved**. Some children are more vulnerable than others. Factors that influence a child's vulnerability include, but **are not limited to:**

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- Younger children who lack good verbal skills, in particular, non-verbal children.
 - Children affected by developmental disabilities/deficits.
 - Children who have serious medical problems.
 - Children who exhibit psychological, emotional, or behavioral problems.
- 2) **Severity of the Behavior/Condition:** Severity of a safety threat must be considered within the context of the other safety threat criteria, child vulnerability and the history of safety threats. Severity may refer to the degree or extent of an alleged maltreatment incident e.g., a child with multiple and/or serious injuries or it may refer to the degree to which a caregiver's behavior threatens child safety, e.g., a caregiver whose substance abuse is severe enough to threaten child safety. Severity is concerned with the degree of potential for harm given the behavior.
- 3) **History:** A safety threat must be considered in the context of any known or alleged previous examples of safety threats. Anecdotal reports about safety threats must be considered, but attempts must be made to verify the information with credible sources. Chronic safety threats must be assessed as posing greater danger to children. Any prior child abuse/neglect history and/or criminal arrest and conviction records, if available, must be evaluated and taken into consideration with respect to child safety.

When there are no safety threats that were checked "YES", the worker is to summarize the available information which indicates that no child is likely to be in immediate danger of moderate to severe harm.

4) **Safety Threat Identification**

Once a safety threat has determined that a child is not safe, identify:

- All children affected.
- The caregiver(s) responsible for creating or allowing the safety threat.
- The source of information identifying the safety threat.

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- f) **CERAP safety assessment threats are listed below with examples to illustrate each of the 16 threats.**

Safety Threats-

- 1) **A caregiver, paramour or member of the household whose behavior is, or has been, violent and/or out of control. Examples of such behavior include, but are not limited to:**
 - A documented or credibly alleged history of violent activity, the nature of which constitutes a threat to a child.
 - Hostile physical or verbal outbursts directed at a child.
 - Behavior that indicates a serious lack of self-control, e.g., acting reckless, unstable, a volatile or explosive temperament towards a child.

- 2) **A caregiver, paramour or member of a household suspected of abuse or neglect that resulted in moderate to severe harm to a child or who has made a plausible threat of such harm to a child. Examples of such include, but are not limited to:**
 - Any caregiver who may have caused or allowed moderate to severe injury to a child.
 - A child who has injuries and reasonable information suggests that they may be non-accidental.
 - An infant with an unexplained injury.
 - Direct or indirect threats, that are believable, to cause harm to a child.
 - Plans to retaliate against a child for causing or cooperating with a CPS investigation.
 - Torture or excessive physical force or punishment.

- 3) **A caregiver, paramour or member of the household who has a documented history of perpetrating child abuse/neglect or any person for whom there is a reasonable cause to believe that he/she previously abused or neglected a child. The severity of that maltreatment, coupled with the caregiver's failure to protect, suggests that child safety may be an urgent and immediate concern. Examples of such include, but are not limited to:**
 - Previous abuse or neglect that was serious enough to cause or could have caused moderate to severe harm.
 - A caregiver is known to have retaliated or threatened retaliation against a child.
 - An escalating pattern of maltreatment.
 - A caregiver who does not acknowledge or take responsibility for prior moderate to severe harm inflicted to a child or tries to explain away prior incidents of moderate to severe harm.
 - Unreported, but credible, anecdotal accounts of prior maltreatment.

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- Efforts to conceal evidence of moderate to severe harm, e.g., child required to wear long pants, long sleeved shirts to conceal bruises or other marks or caregiver applies makeup to conceal marks.
- 4) **Child sexual abuse is suspected and circumstances suggest that child safety may be an immediate concern. Examples of such include, but are not limited to:**
- A child forced or encouraged to engage in sexual performance or activity, including, e.g., sexually gratifying a caregiver or others.
 - A possible or confirmed perpetrator who continues to have access to a child.
 - The caregiver does not believe or support the allegations of sexual abuse made by a child.
 - The child is allowed or forced to watch or read pornographic materials.
- 5) **A caregiver, paramour or member of the household is hiding the child, refuses access, or there is some indication that a caregiver may flee with the child. Examples of such include, but are not limited to:**
- A family has previously fled in response to a CPS or police investigation.
 - A family has removed child from a hospital against medical advice.
 - A family has history of keeping a child at home and/or away from peers, school or other outsiders for extended periods.
 - The family says they may flee or it appears as they are preparing to flee.
- 6) **Child is fearful of his/her home situation because of the people living in or frequenting the home. Examples of such include, but are not limited to:**
- A child cries, cowers, cringes, trembles or otherwise exhibits fear in the presence of certain individuals or verbalizes such fear.
 - A child exhibits severe anxiety (e.g., nightmares, insomnia) that appears to be associated with someone in the home.
 - A child has reason to expect retribution or retaliation from caregivers.
 - A child is isolated from extended family members or others with whom the child feels safe.
- 7) **A caregiver, paramour, or member of the household describes or acts toward the child in a predominantly negative manner. Examples of such include, but are not limited to:**
- Describing a child in demeaning or degrading terms, such as evil, stupid, ugly, a liar, a thief, etc.
 - Cursing at a child in a demeaning, degrading, and/or hostile manner.
 - Using a particular child as a scapegoat.

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- 8) **A caregiver, paramour, or member of the household has dangerously unrealistic expectations for the child. Examples of such include, but are not limited to:**
- The child is expected to perform or act in a way that is impossible or improbable for the child's age, e.g., babies and toddlers expected not to cry or to be still for extended periods; young children to be toilet trained, eat neatly or take responsibility beyond their years.
 - Appearing to interpret child's non-compliance as defiance of caregiver/paramour's authority.
 - Punishment is imposed that is beyond the ability of a child at that age to endure.
- 9) **A caregiver, paramour or member of the household expresses credible fear that he/she may cause moderate to severe harm to a child. An example of such behavior includes, but is not limited to:**
- A father who reports he is going to physically harm his teen-aged son because the child's behavior is out of control.
 - A parent who reports she intends to drop her child out of a 2nd story window.
- 10) **A caregiver, paramour or member of the household has not, will not, or is unable to provide sufficient supervision to protect a child from potentially moderate to severe harm. Examples of such behavior include, but are not limited to:**
- The caregiver places a child in situations that are likely to require judgment or actions greater than the child's level of maturity, physical condition, and/or mental abilities. e.g., although caregiver present, child can wander outdoors alone, play with dangerous objects, play on an unprotected window ledge or be exposed to other serious hazards.
 - A caregiver leaving a child alone longer than would be safe, given the child's age and developmental state.
 - A caregiver makes inadequate or inappropriate child care arrangements or demonstrates very poor planning for a child's care, e.g., a two-year old who is left home alone, a seven-year old who is left to care for his one and two-year old sisters.
- 11) **A caregiver, paramour or member of the household refuses to or is unable to meet a child's medical or mental health care needs and such lack of care may result in moderate to severe harm to the child. Examples include, but are not limited to:**
- A caregiver failing to seek treatment for a child's immediate and dangerous medical or mental health condition.

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- A caregiver does not follow prescribed treatment for any serious medical or mental health condition.
- 12) **A caregiver, paramour or member of the household refuses to or is unable to meet the child's need for food, clothing, shelter, and/or appropriate environmental living conditions. Examples of such include, but are not limited to:**
- A child denied food and/or drink on a consistent or ongoing basis; or
 - A child appearing malnourished.
 - A child without adequate warm clothing in cold months or adequate housing or emergency shelter.
 - A gas leak from a stove or furnace, peeling lead-based paint accessible to a child, or hot water/steam leaks from radiators.
 - Dangerous substances or objects stored in unlocked lower shelves, cabinets, under a sink.
 - A significant amount of raw garbage in the household that has not been disposed of properly.
- 13) **A caregiver, paramour or member of the household whose alleged or observed substance abuse may seriously affect his/her ability to supervise, protect or care for the child. An example of such behavior includes, but is not limited to;**
- A caregiver, paramour or household member whose substance abuse significantly impairs their ability, or is likely to impair their ability, to provide care for a child.
 - A caregiver, paramour or household member's substance abuse would cause them to inflict moderate to severe harm to a child or allow a child to come to moderate to severe harm.
 - A caregiver, paramour or household member's substance abuse extends to selling and or manufacturing drugs while a child is present or in proximity.
- 14) **A caregiver, paramour or member of the household whose alleged or observed mental/physical illness or developmental disability may seriously impair or affect his/her ability to provide care for a child. Examples of such include, but are not limited to:**
- A caregiver who hears voices telling them to harm a child.
 - A child who has become a part of their caregiver's delusional system.
 - A caregiver's behavior that seems out of touch with reality and/or is extremely irrational.
 - A caregiver lacking the physical or intellectual capacity to safely care for a child.
 - A caregiver who is not able and/or willing to engage in needed supports such as medications or mental health services, resulting in harm to a child or likely harm to a child.

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- 15) **The presence of violence, including domestic violence, that affects a caregiver's ability to provide care for a child and/or protection of a child from moderate to severe harm. Examples of such include, but are not limited to:**
- A domestic violence abuser who exhibits controlling behaviors.
 - A domestic violence abuser who has stalked the caregiver and/or child.
 - A domestic violence abuser who has threatened to kill or harm the caregiver and/or child.
 - A domestic violence abuser who recently displayed a violent outburst that resulted in injury or threat of injury to a child or the caregiver while child was in his/her care.
 - A caregiver who is unable to provide basic care and supervision for a child due to an injury or incapacitating condition, forced isolation or other controlling behavior forced upon them by an a domestic violence abuser.
 - A caregiver forced under threat of harm to participate in or witness moderate to severe harm of a child and/or a child being forced under threat of moderate to severe harm to witness or participate in the abuse of the caregiver.
 - A caregiver or child who has injuries the caregiver denies were inflicted by a domestic violence abuser, despite evidence to the contrary.
 - A caregiver with a history of abusing a child after incidents of domestic violence in which the caregiver was the victim.
- 16) **A caregiver, paramour, member of the household or other person responsible for the child's welfare engaged in or credibly alleged to be engaged in human trafficking poses a safety threat of moderate to severe harm to any child in the home. Examples of such safety threats include, but are not limited to:**
- Any caregiver who causes or allows a child to be coerced to perform labor.
 - Any caregiver causing or allowing a child to be used for domestic servitude or peonage (labor provided to settle a debt).
 - Any caregiver who causes or allows a child to be used for commercial sexual exploitation, i.e., prostitution, the production of pornography or for sexually explicit performance.
 - Any caregiver who exposes a child to an environment or set of circumstances that places them at risk of being harmed or exploited, in a manner consistent with the definition of human trafficking.

Safety Threat Description

When safety threats have been identified, describe how the particular threat relates to specific individuals, behaviors, conditions and circumstances.

Note: When **No** safety threats have been identified, indicate the CERAP is Safe. When one or more safety threats have been identified, complete the section entitled Family Strengths Mitigating Circumstances.

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Family Strengths/Mitigating Circumstances

Most often when a safety threat has been identified as present, children must be assessed as unsafe.

When families are themselves able to control behaviors or conditions that would otherwise render their children unsafe, the safety threat is mitigated.

In order for a family strength or action to constitute mitigation, it must take place *on the initiative of family members* and *not* at the suggestion or instigation of the Department. When the Department suggests or instigates an action in response to an identified safety threat, the action is part of a safety plan.

For each safety threat checked “yes” in Section 1, describe in detail any family strengths or actions that mitigate the identified behavior/condition. If one or more safety threats have been identified and **all** identified safety threats are adequately controlled by family strengths or actions, all involved children must be assessed as safe. Identify family members and others responsible for assuring that each mitigating action or circumstance occurs/continues.

Safety threats may be mitigated when:

- 1) **Caregivers, acting on their own initiative, take reasonable action(s) to correct dangerous behaviors/conditions.** For example, a family may move in with relatives while dangerous conditions in the home are corrected.
- 2) **There is an adult caregiver residing in the home who is willing and able to control the identified behavior/condition.** This may be a parent, relative, or other adult who is present in the home (who is not the source of the safety threat) *whenever* affected children are there. In order for a caregiver to be deemed willing and able to control an identified safety factor, he/she must:
 - Demonstrate an understanding of the identified safety threat(s) and the need for protection.
 - Believe that maltreatment may have occurred, is serious, and that the alleged perpetrator(s) may have been responsible.
 - Believably express a willingness and commitment to act to protect all involved children and has not demonstrated an unwillingness or lack of commitment to act to protect all involved children in the past.
 - Believably express a willingness to communicate with Department staff about the family’s situation with particular regard to identified safety threats.
 - Display the physical, intellectual, and emotional capacity to ensure the child(ren)’s protection.

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- 3) **The caregiver(s) responsible for the safety threat are removed from the home.** In order to be considered mitigation, this action must be done *on the initiative of the family*. The absence of an alleged perpetrator because of outside intervention (i.e., arrest) does not constitute *initiative of the family* unless they actively sought law enforcement intervention. As an example of *initiative*, a mother may obtain an order of protection requiring that a violent father leave the home, a substance abusing parent may enter inpatient substance abuse treatment without the intervention of the Department.

When safety threats are mitigated, the assigned worker, in consultation with his or her supervisor, shall ensure the mitigated circumstances remain mitigated through the course of his or her work while assigned to the case. Facts supporting mitigation must be verified and cannot be based solely on self-report. If a safety threat is no longer able to be mitigated, this change in status would require the completion of a new CERAP.

g) **Children, Caregivers, Paramours or Members of the Household Who Were Not Assessed and the Reasons Why**

If a child, caregiver, paramour or member of the household has not been included in the assessment, list who they are and why they were not assessed. When one of these members is assessed and the assessment changes the results of the current assessment, a new CERAP safety assessment must be completed. If the assessment does not change, the worker shall indicate this by opening the “Reason not Assessed” drop down box in the Members tab and returning it to no selection made (blank). The supervisor shall approve the addition of the participant.

If any change in the safety status of any child has been identified at any time, a new assessment must be completed.

h) **Critical Decisions**

CERAP/Safety Decisions - Identify the safety decision as safe or unsafe based upon the assessment of all safety threats and any pertinent mitigating family strengths and/or actions. **This decision requires supervisory consultation via phone at the time of assessment.**

- 1) If **no** safety threats are identified, all involved children **must** be assessed as safe.
- 2) If one or more safety threats have been identified and **all** identified safety threats are adequately controlled by family strengths or actions, all involved children must be assessed as safe. **The fact that a child might be safe is independent from the decision regarding whether the allegation is indicated or not. A child may be safe from further abuse at the hands of a removed perpetrator, but that does not negate the fact that they were abused.**

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- 3) If one or more safety threats have been identified and all identified safety threats are **not** controlled (mitigated) by family strengths or actions, all children affected by the unmitigated safety factor **must** be assessed as unsafe.

When a decision is made that a child is unsafe, a safety plan must be developed and implemented or protective custody must be taken to avoid immediate danger to a child.

i) Signatures and Distribution of Form

The CERAP must be completed by the assigned worker and approved by the respective supervisor after completion. The supervisor or **designee** shall approve the CERAP within 24 hours after the worker has completed it, if a safety threat has been marked “unsafe”. If no safety threat has been marked unsafe and the worker has completed the **CERAP** on a weekend or holiday and more than 24 hours will elapse before the supervisor or designee can approve, the supervisor or designee shall approve the form on the next working day.

j) Safety Planning

Safety plans are voluntary, temporary and short term measures designed to control serious and immediate threats to children's safety. They must be adequate to ensure the child's safety and be as **minimally disruptive** to the child and family as is reasonably possible. Additionally, families can request that a safety plan be modified or terminated at any time. The Safety Plan will indicate which Safety Threat or Threats have led to the need for a Safety Plan according to the completion of the CERAP. The Safety plan will require a written description of what will be done or what actions will be taken to protect children, who will be responsible for implementing the components of the safety plan and how/who will monitor it. It is important that safety plans be developed with the family to control specific threats and that the family understands the mechanism for ending each safety plan. Under no circumstance is a safety plan to serve as the solution to a long-term problem. A family may request at any time to modify or terminate the safety plan.

When a safety plan is implemented, it should be documented on a **CFS 1441-A** when it is likely that a child could be moderately or severely harmed now or in the very near future. The safety plan must be developed whenever there are protective efforts that would reasonably ensure child safety and permit the child to remain in their caregiver's custody. After the safety plan has been developed, it must be immediately implemented to ensure that all of the designated tasks are completed effectively. The safety plan should contain timeframes for implementation and continued monitoring.

The family must be informed that their participation in the development and implementation of the safety plan is voluntary and, to the extent safely possible, the worker must enlist the family's participation in the safety plan's development **Consideration should be given to a non-custodial parent when developing the safety plan.** The worker must consider the legal relationship between the alleged perpetrator and the alleged child victim and other children in the home who will be involved in the safety plan. Persons legally responsible for

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the child (this includes biological parents) have the right to make decisions with respect to their child, even when this person is the subject of a child abuse or neglect investigation. When developing a safety plan with the family, the worker should include those legally responsible for the child in every aspect of safety planning when possible. If the worker is unable to include an individual who is legally responsible for the child, the worker will make every effort to contact the individual as soon as possible to discuss the safety plan. Consideration should be given to those individuals the child identifies as a person with whom he/she feels safe and trusts.

When a biological parent or person legally responsible for the child indicates he or she is divorced, in the process of divorcing or involved in court proceedings regarding custody of the child, the worker must ask the individual about any custody or visitation agreements that are in place as a result of a divorce or a court order. When circumstances meet the standard to take protective custody, the Department and other agents authorized by law can take protective custody regardless of the existence of court-ordered custody or visitation plans. If there is an existing court-ordered custody or visitation schedule, any party to the court order whose rights are affected by the safety plan must voluntarily agree to the terms of the safety plan by signing it. The worker should request any court orders or custody agreements that the individual can provide. If the worker feels there is a need to request the individual forego his or her visitation according to a court order or court approved agreement in order to implement a safety plan, the individual would need to agree to voluntarily suspend his or her visitation. If the person legally responsible for the child does not agree to the safety plan, the worker should consult with his or her supervisor for further direction. Possible solutions could be developing another safety plan that can be agreed upon, one of the legally responsible individuals going to court to modify the custody provisions or taking protective custody.

Workers and supervisors must remember that a safety plan cannot be implemented after protective custody has lapsed due to the local State's Attorney office NOT filing a petition in Juvenile Court, unless relevant new facts are learned. When a States Attorney Office declines because further information is needed, it is not the same as a refusal to file.

When the safety plan is developed, the worker must explain it to the family and must inform the family about the potential consequences if the safety plan is refused or violated. If the family refuses to accept the safety plan or if the safety plan is violated, the worker must reassess the situation. Upon reassessment, the worker shall inform the family of the need to develop a new safety plan, possible protective custody and/or a referral to the State's Attorney's Office for a court order. The worker shall document the family's agreement and commitment in the appropriate case record as described below under Signatures and Distribution of Safety Plan.

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k) In-home Safety Plans

Some safety plans may be implemented with family members remaining together. When in-home safety plans adequately ensure child safety they are preferable because they are less disruptive to the lives of children and families. Required factors for in-home safety plans include all of the following:

- The caregivers are willing to implement the in-home safety plan and be reasonably cooperative with those persons participating in carrying out the safety plan.
- Steps outlined in the safety plan must be **immediate**.
- The safety plan must be action-oriented and contain specific changes needed to control identified safety threats.
- Safety plans must **never** be based on promissory commitments from caregivers, e.g., an abuse perpetrator promises to attend counseling or not to use excessive corporal punishment or a neglectful perpetrator promises not to leave children unsupervised.
- The safety plan must be reasonable and sustainable for the family.
- Consider should be given to the involvement of those individuals the child identifies as a person with whom he/she feels safe and trusts.

l) In-home Safety Plan: Protective Caregiver

In-home safety plans may include the introduction of a protective caregiver into the home. The DCFS or private agency worker must work with the family to identify someone willing and able to fulfill the protective caregiver role. The protective caregiver is to oversee and supervise all child care activities whenever the children are present. It is not realistic to expect that a protective caregiver can prevent all unsupervised contact between the child and the caregiver responsible for the safety threat when they reside in the same home. Therefore, if any unsupervised contact between the child and the caregiver responsible for the safety threat constitutes a danger to the child, the introduction of a protective caregiver may be inadequate. Protective caregivers must:

- demonstrate an understanding of the identified safety threat(s) and a child's need for protection.
- believe and understand that maltreatment may have occurred and that the alleged perpetrator(s) may have been responsible.

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- believably express a willingness and serious commitment to act to protect involved children.
- have a credible explanation for why they did not intervene to insure child safety in the past, if there were signs of danger to a child that could reasonably have been noticed and acted upon.
- believably express a willingness to communicate with Department staff about the family's situation regarding identified safety threats.
- display the physical, intellectual, and emotional capacity to ensure a child's protection.

Note: A CANTS and LEADS check must be completed on all protective caregivers in order to consider the appropriateness of the potential caregiver.

m) **In-home Safety Plan: Removal of Alleged Perpetrators**

When there are two caregivers who have a legal relationship with the child and both are present, both must sign the safety plan. Some in-home safety plans may include the **voluntary** removal of the caregiver responsible for the safety threat. In such cases the “non-offending” caregiver must:

- Demonstrate an understanding of identified safety threats and the need for protection.
- Believe and understand that maltreatment may have occurred and that the caregiver removed from the home may have been responsible.
- Believably express a willingness and commitment to protect all involved children.
- Believably express a willingness to communicate with Department staff about the family's situation with respect to identified safety threats.
- Display the physical, intellectual, and emotional capacity to ensure child protection.

Example: a grandmother agrees to call the Hotline in the event that the dangerous caregiver returns to the home.

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n) **In-Home or Out of Home Safety Plan Requirements for Alternate Protective Caregivers**

Safety plans may include stipulations that children be **temporarily and voluntarily** moved to the home of a protective caregiver, e.g., the home of a relative or friend. In order for a protective caregiver to be deemed willing and able to control an identified safety threat she/he must:

- Demonstrate an understanding of identified safety threats and the need for child protection.
- Believe and understand that maltreatment may have occurred, and that the alleged perpetrator(s) may have been responsible.
- Believably express a willingness and commitment to act to protect all involved children.
- Believably express a willingness to communicate with Department staff about the family's situation with respect to identified safety threats.
- Display the physical, intellectual, and emotional capacity to ensure child protection.
- Agree to continue with the child's current academic and social activities.

In addition,

- A SACWIS and LEADS check must be completed on all adult members of the protective caregiver's home.
- The physical environment of the protective caregiver's home must be assessed for safety hazards.

Every safety plan must specify the conditions under which the safety plan is to be terminated and a time frame when this can be expected to occur. Though safety plans are voluntary and developed in cooperation with the family, the safety plan must also explain the consequences if the caregiver does not agree to implement or fails to carry out the terms of the safety plan. Failure to agree to or carry out the safety plan may result in a reassessment of the home and possible protective custody and/or referral to the State's Attorney's Office for a court order to remove the children from the home. The worker developing the safety plan must stress with the protective caregiver that the safety plan is a voluntary, short-term agreement and the legal parent retains all of his or her rights.

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o) **Signatures and Distribution of the Safety Plan**

A completed safety plan must be given verbal approval by the supervisor or his/her designee by phone, then signed and dated by the primary caregiver and the DCFS or private agency worker. The completed safety plan must also be signed by any other persons responsible for implementing the safety plan, as well as any other persons responsible for components of the safety plan.

A copy of the completed **CFS1441-A** shall be given to the primary caregiver, and to the protective caregiver identified in the safety plan, if other than the primary caregiver. The worker will ensure that other individuals involved in the safety plan also receive a copy of the **CFS 1441-A**. The DCFS or POS agency worker shall include on the form the contact information for the worker and the approving supervisor. The original shall be placed in the child/family case file of the child protection investigator or the assigned caseworker and forwarded to the appropriate service worker when a case is transferred.

The respective supervisor or designee shall approve the completed safety plan within 24 hours after the worker has signed it. If the worker has signed the **CFS 1441-A** on a weekend or holiday and more than 24 hours will elapse before the supervisor can approve the safety plan, the supervisor shall then approve the safety plan in SACWIS on the next working day.

In all other instances when the supervisor who gave verbal approval will not be available to approve the safety plan in SACWIS, due to a prolonged absence, another supervisor may approve the safety plan.

p) **Responsibility for Monitoring and Managing Safety Plans**

Department staff must ensure that the caregiver responsible for the safety threat has not returned to the home. Department staff may seek assurances that a caregiver responsible for a safety threat has not returned to the home by talking with children or other adults in the home, discussing with neighbors, visiting where the alleged perpetrator currently resides, speaking to school staff, etc. A new CERAP safety assessment must be completed every five working days following the determination that any child in a family is unsafe and a safety plan is implemented. Such assessment must continue until either all children are assessed as being safe, the investigation is completed or all children assessed as unsafe are removed from the legal custody of their parents/caregiver and legal proceedings are being initiated in Juvenile Court. This assessment should be conducted considering the child's safety status as if there was no safety plan, i.e., would the child be safe without the safety plan? This CERAP safety assessment will determine the point at which a safety plan may be terminated or its conditions modified. When a safety plan has been modified, the worker must obtain the signatures of the parent/caregivers and other adult participants on a new **CFS 1441-A** and provide the parent/caregivers and other adult participants with a copy of the new **CFS 1441-A** documenting the conditions of the modified safety plan.

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When a worker implements a safety plan and discovers through the course of his/her work that a safety threat has been **eliminated**, the worker should immediately discuss this with his or her supervisor in order to assess the need to modify or end the safety plan.

When a safety plan is implemented as the result of a Child Protection Investigation, all monitoring and management of the safety plan is the responsibility of the Investigation Specialist. When an investigator implements a safety plan for which he/she will not be responsible, e.g., the investigative specialist on call, the investigator or supervisor will staff the safety plan with the receiving investigator. The receiving investigator will ensure that all involved parties in the safety plan are provided with his/her contact information as the worker responsible for monitoring the plan. The original investigator or supervisor will document the safety plan staffing in a SACWIS note.

If there is an open Intact Service case and investigation is open as well, the Investigative Specialist remains responsible for monitoring the safety plan until the investigation is closed. If a safety plan remains in place after the investigation is closed, the Intact Service worker acquires the responsibility for monitoring the safety plan at the transition visit. When cases are transferred, the worker transferring the case shall discuss the case and the terms of the safety plan with the new worker at the time of the case transfer. This responsibility is applicable regardless of whether the worker is DCFS or POS staff.

The Department retains sole responsibility for monitoring safety plans. Under no circumstance may safety plan monitoring be delegated to family members or any other persons.

q) Ending Safety Plans

Safety plans are terminated:

- When the family no longer wishes to participate voluntarily in the safety plan.
- When the safety threats are no longer present and the safety plan is no longer needed.
- At the conclusion of the investigation, regardless of the final finding of the case, unless there is an open service case.
- When the safety plan implemented is not sufficient to control safety threats and an alternate safety plan must be developed.

The responsible worker must terminate the safety plan using the CFS 1441-B form. A copy of the form must be provided to those legally responsible for the child and those who agreed to be a part of the safety plan.

Under no circumstance may contracted or Department staff terminate Department involvement while a safety plan is in effect.

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

POLICY GUIDE 2019.03

**PROCEDURES 300 APPENDIX G
and
PROCEDURES 315, APPENDIX A**

CHILD ENDANGERMENT RISK ASSESSMENT PROTOCOL

DATE: February 26, 2019
TO: DCFS and POS Staff
FROM: Debra Dyer-Webster, Interim Director
EFFECTIVE: Immediately

I. PURPOSE

The purpose of this Policy Guide is to inform Child Protection and Child Welfare staff of changes to **Procedures 300, Appendix G Child Endangerment Risk Assessment Protocol (CERAP)** and **Procedures 315, Appendix A Child Endangerment Risk Assessment Protocol (CERAP)** and the **CFS 1441 CERAP Safety Determination Form, 1441-A Safety Plan, CFS 1441-D Safety Plan Rights and Responsibilities for Parents and Guardians, CFS 1441-E Safety Plan Rights and Responsibilities for Responsible Adult Caregivers and Safety Plan Participants** and the **CFS 1441-F Safety Plan Responsibilities for Investigators and Caseworkers**. The **CFS 1441** will be revised in SACWIS so the hard copy and corresponding electronic version matches each other. These changes, in part, are to implement court ordered requirements into the policy and practice of child safety. The changes in this policy guide will be included in a comprehensive revision of **Procedures 300, Appendix G** and **Procedures 315, Appendix A** in the near future.

II. PRIMARY USERS

The primary users of this Policy Guide are Child Protection Specialists/Supervisors and DCFS/POS Child Welfare Specialists/Supervisors.

III. BACKGROUND

The CERAP safety assessment is a life-of-the-case protocol designed to provide workers with a mechanism for quickly assessing the potential for moderate to severe harm in the immediate or near future and for taking quick action to protect children. The safety assessment is conducted at specified milestones, including every 5 working days following the determination that a child is **unsafe** and a safety plan has been implemented.



IV. INSTRUCTIONS

Changes in **Procedures 300, Appendix G** and **Procedures 315, Appendix A (CERAP)** include, but are not limited to:

- Added new language to **Milestone #4-**
 - **Current Language** – “At the conclusion of the formal investigation, unless temporary custody is granted or there is an open intact case or assigned caseworker. The safety of all children in the home, including alleged victims and non-involved children, must be assessed.”
 - **New Language** – “At the conclusion of an investigation, unless a service case is opened. All children in the home, alleged victims and non-involved children must be included in the assessment. When the initial assessment is marked safe and no more the 30 days have lapsed since it was completed, a closing assessment is not needed unless otherwise directed to do so by a supervisor.”
- Added new language to **Safety Threat #14-**
 - **Current Language-** “A caregiver, paramour or member of the household whose alleged or observed mental/physical illness or developmental disability may seriously impair or affect his/her ability to provide care for a child.”
 - **New Language-** “A caregiver, paramour or member of the household whose observed or professionally diagnosed or documented mental/physical illness or developmental disability seriously impairs his or her ability to meet the immediate needs of the child.”

Changes in the forms listed below include, but are not limited to:

- **CFS 1441 (amended in SACWIS also)**
Includes the revised Milestone #4 and Safety Threat #14, as noted above.
- **CFS 1441-A (amended in SACWIS also)**
New language in Section III states that a safety plan may be developed only when based on the reasonably available information/evidence that DCFS possesses, that there is an immediate and unmitigated safety threat that would cause moderate to severe harm to a child unless protective custody was taken.

New language states that Safety Plans should not include a requirement of individual or family therapy or outpatient/inpatient mental health treatment.

New language states that a new safety assessment and safety plan is required every 5 working days and that a copy signed by all parties shall be distributed to the parties upon verbal supervisory approval.

In the Signature section, adds new language for an attestation by the assigned Specialist that a signed copy of the safety plan has been added to the hard copy file and a copy provided to all parties.

- **CFS 1441-D**
New language establishes that a parent/guardian has the right to receive a copy of all signed safety plans.
- **CFS 1441-E**
New language establishes that adult caregivers and safety plan participants have the right to identify and recommend individuals who may provide care for their child and/or participate as a safety plan monitor/supervisor.
- **CFS 1441-F**
New language states that a new safety assessment and safety plan must be performed and approved by the supervisor every 5 working days.

New language states that all parties must receive a signed copy of each written safety plan and that a hard copy of the signed plan is retained in the investigative file.

V. NEW/REVISED FORMS

CFS 1441, CERAP Safety Determination form (Rev 2/2019)

CFS 1441-A, Safety Plan Form (Rev 2/2019)

CFS 1441-D, Safety Plan Rights & Responsibilities for Parents and Guardians (Rev 2/2019)

CFS 1441-E, Safety Plan Rights & Responsibilities for Responsible Adult Caregiver & Safety Plan Participants (Rev 2/2019)

CFS 1441-F, Safety Plan Responsibilities for Child Protection Specialists and Caseworkers (Rev 2/2019)

All previous versions of these forms are now obsolete. Forms are available on the DCFS website, Template (T) drive, and can be ordered in the usual manner.

VI. QUESTIONS

Questions about this policy guide should be directed to the Office of Child and Family Policy at 217-524-1983 or via Outlook to DCFS.Policy@Illinois.gov.

VII. FILING INSTRUCTIONS

This Policy Guide is to be filed immediately following **Procedures 300, Appendix G and Procedures 315, Appendix A, Child Endangerment Risk Assessment Protocol.**

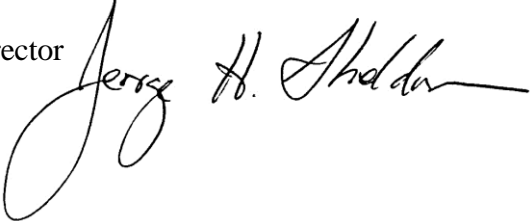
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DEPARTMENT OF CHILDREN AND FAMILY SERVICES

POLICY GUIDE 2016.10

Replaces PG 2014.20

**Procedures 300 Reports of Child Abuse and Neglect
Procedures 302 Services Provided by the Department
Procedures 315 Permanency Planning**

DATE: August 26, 2016
TO: All Child Protection and DCFS/POS Child Welfare Staff and Supervisors
FROM: George H. Sheldon, Director 
EFFECTIVE: Immediately

I. PURPOSE

The purpose of this Policy Guide is to provide Child Protection and Child Welfare staff for with revised and updated Safety Plan Rights and Responsibilities for Parents and Guardians, Safety Plan Rights and Responsibilities for Adult Caregivers and Safety Plan Participants and Safety Plan Rights and Responsibilities for Investigators and Caseworkers. The updated forms provide additional information for parents and caregivers, adult caregivers and safety plan participants and investigators and caseworkers regarding the formulation of the safety plan, the information that needs to be detailed in the safety plan document, the process for modification of safety plans and the process for continual review of safety plans.

The instructions in this Policy Guide will be incorporated into **Procedures 302.250 Paramour Involved Families; 302.260 Domestic Violence; 302.388, Intact Family Services, 302 Appendix A Substance Affected Families; 302 Appendix B Older Caregivers; Procedures 315.110 Worker Contacts and Interventions; Procedures 315 Appendix A CERAP and Procedures 300 Appendix G CERAP.**

This Policy Guide is effective immediately.

II. PRIMARY USERS

Primary users are all Child Protection Specialists and Supervisors and all DCFS/POS Child Welfare Workers and Supervisors.



III. BACKGROUND

Procedures 300 Appendix G CERAP/Procedures 315 Appendix A CERAP (Current)

Safety Plans

Safety plans are voluntary, temporary and short term measures designed to control serious and immediate threats to children's safety. They must be adequate to ensure the child's safety and be as **minimally disruptive** to the child and family as is reasonably possible. Additionally, families can request that a safety plan be modified or terminated at any time. The safety plan will indicate which safety threat or threats have led to the need for a safety plan according to the completion of the CERAP. The safety plan will require a written description of what will be done or what actions will be taken to protect children, who will be responsible for implementing the components of the safety plan and how/who will monitor it. It is important that safety plans be developed with the family to control specific threats and that the family understands the mechanism for ending each safety plan. **Under no circumstance is a safety plan to serve as the solution to a long-term problem. A family may request at any time to modify or terminate the safety plan.**

When a safety plan is implemented, it should be documented on a **CFS 1441-A, Safety Plan** when it is likely that a child could be moderately or severely harmed now or in the very near future. The safety plan must be developed whenever there are protective efforts that would reasonably ensure child safety and permit the child to remain in their caregiver's custody. After the safety plan has been developed, it must be immediately implemented to ensure that all of the designated tasks are completed effectively. The safety plan should contain timeframes for implementation and continued monitoring.

IV. OVERVIEW

Public Act 98-0830 amended Section 21 (f) of the Children and Family Services Act [20 ILCS 505/21] and required the Department or POS caseworker to provide information to each parent, guardian and adult caregiver participating in a safety plan explaining their rights and responsibilities. These updated forms add additional information to the Safety Plan Rights and Responsibilities forms with the following information:

- The investigator and caseworker shall implement a safety plan only when DCFS has a basis to take protective custody of a child(ren) and the safety plan is an alternative to protective custody;
- The investigator and caseworker shall explain to the parent(s)/guardian(s) the safety plan alternatives and that the parent(s)/guardian(s) have a voluntary choice to enter into the safety plan as an alternative to protective custody and to choose the individual(s) responsible for supervising or monitoring the safety plan if such person(s) is/are determined to be qualified by DCFS;
- The investigator and caseworker shall modify the safety plan if the family's circumstances change or if the participants request modifications, including a change in the person(s) preferred by the parent(s)/guardian(s) to supervise or monitor the safety plan or serve as a temporary caregiver;

- Terminate the safety plan as soon as the investigator and/or supervisor determine there is no longer a legal basis to take protective custody and provide the parent(s)/guardian(s) with the Safety Plan Termination form; and
- The Department or POS representative shall ensure that the safety plan is reviewed and approved by their respective supervisor.

V. INSTRUCTIONS

Effective immediately:

- Child Protection and Child Welfare staff shall provide the parent, guardian and adult caregiver participating in a safety plan with a copy of the **CFS 1441-A, Safety Plan** that has been signed by all adult participants and the DCFS/POS representative;

Note: Department and POS staff must use only the **CFS 1441-A, Safety Plan (Rev 12/2014)** that has been revised to meet the requirements of PA 98-0830.

- The Department or POS representative shall provide each parent/guardian, adult caregiver and safety plan participant with information explaining their rights and responsibilities including, but not limited to: information for how to obtain medical care for the child, emergency contact information for participants including phone numbers and information on how to notify schools and day care providers of safety plan requirements. The rights and responsibilities of each parent/guardian, adult caregiver, safety plan participant and child protection/child welfare staff are listed in new forms **CFS 1441-D, Safety Plans Rights and Responsibilities for Parents and Guardians; CFS 1441-E, Safety Plan Rights and Responsibilities for Responsible Adult caregivers and Safety Plan Participants; CFS 1441-F, Safety Plan Responsibilities for Child Protection Specialists and Child Welfare Caseworkers**. All **CFS 1441** forms are available in central stores, templates, and the website; and
- After receiving verbal supervisory approval of the safety plan prior to leaving the family home, the Department or POS representative shall submit the signed **CFS 1441-A** to their respective supervisor for review and approval.

VI. ATTACHMENTS

CFS 1441-D, Safety Plans Rights and Responsibilities for Parents and Guardians (Revised 08/2016);

CFS 1441-E, Safety Plan Rights and Responsibilities for Responsible Adult caregivers and Safety Plan Participants (Revised 08/2016); and

CFS 1441-F, Safety Plan Responsibilities for Child Protection Specialists and Child Welfare Caseworkers (Revised 08/2016).

Please note that the **CFS 1441-A** is printed on a 6 Part form and available from Central Stores. The **CFS 1441-D – F** are printed on regular paper and available from Central Stores, DCFS Website and T drive. All forms will be available in Spanish.

VII. QUESTIONS

Questions regarding this Policy Guide may be directed to the Office of Child and Family Policy at 217-524-1983 or via Outlook at OCFP – Mailbox. Non Outlook users may e-mail questions to cfpolicy@idcfs.state.il.us.

VIII. FILING INSTRUCTIONS

Remove and replace Policy Guide 2014.20 with this Policy Guide immediately after **Procedures 302.250 Paramour Involved Families; Procedures 302.260 Domestic Violence; Procedures 302.388 Intact Family Services; Procedures 302 Appendix B Older Caregivers; Procedures 315.110 Worker Contacts and Interventions; Procedures 315 Appendix A CERAP and Procedures 300 Appendix G CERAP.**

REPORTS OF CHILD ABUSE AND NEGLECT

March 12, 2004 – PT 2004.07

APPENDIX H – PARAMOUR INVOLVED FAMILIES

I. Purpose

This Appendix establishes procedural guidelines for the intake and investigation of alleged incidents of child abuse and neglect where a paramour is or is suspected of being part of the family unit.

II. Definition of Paramour

“Paramour” means a current or ex-boyfriend or girlfriend who has been or may be or is in a care-taking role. The paramour may or may not be residing within the family unit. Paramour involved families may be identified at the time of intake, during a child abuse or neglect investigation or anytime during the life of an open service case.

Note: A putative father would fall under the definition of paramour.

III. Identification of Paramour Involved Families

State Central Register (SCR) staff shall use the screening and assessment factors listed below to screen calls of alleged paramour inflicted physical abuse. LEADS checks should be initiated by SCR staff for reports of physical abuse or risk of non-sexual physical abuse where a paramour is identified as the alleged perpetrator.

Child Protective Service Workers (CPSW) shall assess single parent households to determine if a paramour is involved with the parent and children regardless of whether there is acknowledgement by the family that a paramour lives in the household or is significantly involved with the parent and children. The assessment shall include information obtained from the parent, children, extended family, reporter, paramour, school personnel and other social service personnel in order to make an informed assessment of the paramour’s involvement with the family that is essential to the development of viable safety and service plans.

IV. Screening and Assessment

Upon determination by CPSW that a paramour is involved or suspected of being involved with the family the worker shall utilize the following factors to assess level of risk and safety to the children in the household. Information gathered shall address the characteristics of the paramour, the dynamics of the relationship between the custodial parent and paramour, the custodial parent’s history with paramours and spouses, the custodial parent’s capacity to protect his or her children from abuse, and child factors that may increase the risk of abuse by a paramour.

The Paramour Assessment Checklist has been designed to aid in the identification of risk and safety issues specific to paramour involved cases. A “yes” response to any of the listed factors requires that the factor or factors be considered when completing the CERAP, safety plan development/implementation and/or service planning. A “yes” response to any of the factors may or may not require implementation of an intervention to address the identified issue. This decision must be made in consultation with the CPSW supervisor.

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March 12, 2004 – PT 2004.07

a) Application of Paramour Factors

A **CFS 1441, Safety Determination Form**, must always be completed in accordance with the Child Endangerment Risk Assessment Protocol and a safety plan implemented when a child is found to be unsafe. When there are circumstances that mitigate factor number 14 of Section 1 of the **CFS 1441** (i.e., A paramour is the alleged or indicated perpetrator of physical abuse.), paramour procedural requirements may be waived by a CPSW manager after consultation with the CPSW. The consultation and waiver must be documented in a **SACWIS Case Note**.

- 1) Paramour requirements in Section V *cannot* be waived if any of the following factors is answered “yes.” If any child is found to be unsafe, then an appropriate safety plan must be developed and implemented.
 - A) The paramour expresses negative attitudes or behaviors towards specific children in the household (e.g., unrealistic expectations for behavior, demeaning verbalizations, excessive corporal punishment, differential treatment as compared to other children in the home, etc.).
 - B) The paramour has been previously indicated as a perpetrator of child abuse or neglect.
 - C) The paramour has a history as an indicated perpetrator of child abuse or neglect in another state.
 - D) There is a history of domestic violence involving the paramour and the custodial parent.
 - E) The custodial parent and/or children express fear of the paramour.
- 2) The supervisor *may* waive paramour procedural investigation requirements established in Section V if any of the following factors are answered “yes”.
 - A) The paramour is financially dependent on the custodial parent.
 - B) The paramour is misusing alcohol, prescription drugs, over the counter or illegal drugs.
 - C) The paramour has a criminal background established through a LEADS and local law enforcement records check.
 - D) The paramour has a history of mental illness including a history or current hospitalization and/or treatment.
 - E) There is suspicion of domestic violence involving the paramour and the custodial parent.

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- F) The custodial parent has a history of domestic violence with previous paramours or spouses.
- G) The children are ages 0-10. (Note: Children who are ages six through ten years of age are at high risk and children who are younger than six years of age are at the greatest risk of abuse.)
- H) The children are hyperactive, behaviorally disordered, sexual behavior problems, physically or mentally handicapped.
- I) There is another adult in the home who is willing and able to assist with ensuring the safety of the children.

Note: This person cannot have a criminal history or have been indicated for abuse or neglect as verified through SACWIS/CANTS, LEADS or law enforcement agency checks.)

- J) There is a current or pending order of protection against the paramour.
- K) The paramour has a history of multiple unstable adult relationships.

Note: Blended families involving multiple children with different biological parents often-present situations that prevent bonding between the custodial parent, paramour and children, creating a greater risk for abuse.

- L) The paramour has a history of domestic violence.

b) Strengths

The basis for a significant, continuous, and stable relationship is established if all the factors in this section are answered “yes.” A “no” response to any of the factors may or may not require the implementation of an intervention to address the identified issue. Factors with a “no” response should be considered when completing the **CFS 1441**.

- 1) The custodial parent and his or her children refer to the paramour in positive, affectionate terms to others such as school personnel or extended family.
- 2) The paramour refers to each child by name in positive, affectionate terms.
- 3) The paramour is actively involved in child rearing (e.g., childcare, transportation, extra curricular activities, school conferences, provider for medical insurance, medical appointments, etc.).

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- 4) Persons outside the home refer to the paramour as having a positive relationship with the involved children.
- 5) Persons outside the home are able to provide examples of the paramour's positive contributions to the involved children's well being.
- 6) The paramour's family recognizes his or her involvement as a "parent" to the involved children who are not his or her biological children.
- 7) The paramour and custodial parent have established a joint residence.
- 8) The paramour provides emotional support to the custodial parent and/or involved children
- 9) The paramour provides consistent financial support to the family.
- 10) The custodial parent puts the child's interest above his or her need for a relationship.
- 11) The custodial parent has the ability and willingness to protect his or her children from abuse or neglect.

V. Investigation

The following procedures shall be followed for all cases where a paramour has been named as an alleged perpetrator or identified as being involved with the family.

a) Interviewing Children of Paramour Households

Child victims and non-involved subject children shall be interviewed in a neutral setting without the paramour and/or parent present. Interviews should be conducted in a neutral setting such as a school, day care center, extended family home, DCFS office or any other environment perceived as "safe" by the child. Interviews conducted in the home must be done in an area where the paramour and parent are unable to have eye contact with the children or hear the children's statements.

b) Referral to Law Enforcement

A referral to law enforcement must be made and protective custody considered when the investigator is denied access to the children by the paramour and the natural parent is unable or unwilling to permit access. Child Protective Service Workers may request a waiver of these requirements from Child Protection Unit supervisors. The **SACWIS Case Note** shall be used to document the supervisor's consultation and information supporting the supervisor's decision to either approve or deny the waiver request.

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c) Interviewing Non-Offending Custodial Parent

Separate interviews must be conducted with the paramour and custodial parent. A non-offending custodial parent who is fearful of his or her paramour should be interviewed in a neutral setting.

d) Corroboration of Credible Information

Corroboration of credible information must be sought concerning a custodial parent or paramour's history of alleged mental illness, domestic violence, drug and/or alcohol abuse, or abusive patterns of discipline when the paramour or natural parent denies such histories.

e) Safety Plan

An appropriate safety plan must be developed and implemented, if required, and documented on the **CFS 1441**. This plan may require that the paramour leave the custodial parent's residence during the investigation. Shelters or extended family should be considered for use as temporary living quarters for custodial parents and children in those situations where they reside in the paramour's home.

The custodial parent should be informed that permitting his or her paramour access to children in violation of an established safety plan may result in the Department taking protective custody of the children and referring the case to Juvenile Court.

f) Formal Investigation Procedural Requirements

The following are required for all cases that proceed to formal investigation:

1) Collateral Contacts

Child Protective Service Workers must make collateral contacts with individuals who can provide information concerning the safety and well being of the children, parental functioning, the quality of the home environment, and the quality and stability of the relationship between the paramour, custodial parent and the custodial parent's involved children (e.g., extended family members who have had extensive/significant personal contacts, child care providers, social service agencies, neighbors, school and medical personnel).

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2) Referral to Law Enforcement

Cases must be referred to law enforcement unless the Department has a written agreement not to refer such cases or a waiver of the requirement has been obtained from the Child Protection Unit supervisor. The **SACWIS Case Note** shall be used to document the supervisor's consultation and information supporting the supervisor's decision to either approve or deny the waiver request.

3) Serious Physical Injury Cases

Serious physical injury cases must be referred to Child Advocacy Centers where the Department is served by such centers unless a waiver of the requirement has been obtained from the Child Protection Unit supervisor. The **SACWIS Case Note** shall be used to document the supervisor's consultation and information supporting the supervisor's decision to either approve or deny the waiver request.

4) Paramour Assessment Checklist

A **Paramour Assessment Checklist, SACWIS/CANTS 17A/Paramour**, must be completed.

5) Monitoring Visits with Involved Children

Monitoring visits with the involved children shall occur weekly during the course of all pending formal investigations when the following conditions exist:

- A) a child victim is under ten years of age; or
- B) a child victim is vulnerable to physical abuse and injury due to a handicapping condition; or
- C) a child victim has been seriously injured.

The assigned Department or purchase of service agency permanency worker shall monitor families with open service cases unless other arrangements are made with the investigator. Monitoring visits shall be documented on the **SACWIS Case Note**.

Child Protection Unit/Child Welfare supervisors may grant a waiver of this requirement. The **SACWIS Case Note** shall be used to document the supervisor's consultation and information supporting the supervisor's decision to either approve or deny the waiver request.

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6) Referral for Services

When possible, families shall be referred for services within 24 hours after identification of service needs and transitioned to follow-up services within 72 hours of the referral. The assigned permanency worker shall provide weekly monitoring with the involved children unless arrangements are made with the Child Protective Service Worker to conduct the visits. Monitoring visits shall be documented on the **SACWIS Case Note**.

7) Mandatory Case Opening

A case must be referred for mandatory case opening when a paramour is indicated for physical abuse and any of the following conditions exist:

- A) a child victim is under eleven years of age; or
- B) a child victim is vulnerable to abuse and injury due to a handicapping condition; or
- C) a child victim has been seriously injured.

Cook County Child Protection Managers may grant an exception to this requirement after consultation with the Child Protection Unit supervisor and investigator. For all other cases, Child Protection and Field Services Managers/Site Administrators may grant the exception after consultation with the Child Protection Unit supervisor and investigator. Management consultations and decisions with supporting information shall be documented on the **SACWIS Case Note**.

8) Referral for Assessment and Case Opening

A case must be referred for assessment and case opening when a paramour is indicated for physical abuse and any of the following conditions exist:

- A) child victims are ten years of age or older;
- B) child victims have no handicapping conditions that make them vulnerable to abuse and injury; and
- C) child victims have not been seriously injured.

Child Protection Unit supervisors may grant exceptions to the referral for assessment and case opening requirement with approval from the Child Protection Manager. Management consultations and decisions with supporting information shall be documented on the **SACWIS Case Note**.

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9) Final Finding Report

When the decision to unfound the report has been made, but prior to completion of the Final Finding Report, the Child Protective Service Worker shall re-interview the reporter and respond to any additional issues raised by the reporter.

Mandated reporters shall also be provided the reasons for the recommended unfounded finding and be advised of his or her statutory right to request a review of the finding by a Multidisciplinary Review Committee [Procedures 300.60(n)].

10) Unfounded Cases that Exceed 14 Days

The following are required for all unfounded cases that go beyond 14 days:

- A) pre-school and non-verbal alleged child victims must be observed, and older alleged child victims re-interviewed within 72 hours prior to the date the Child Protective Service Worker submits the completed investigative file to the Child Protection Unit supervisor for final approval;
- B) a closing body chart on alleged child victims must be completed unless a waiver is obtained from the Child Protection Unit supervisor. The **SACWIS Case Note** shall be used to document the supervisor's consultation and information supporting the supervisor's decision to approve the waiver request;
- C) LEADS checks and background checks with other states where the paramour is known or alleged to have lived must be completed; and
- D) a risk factor must be added to the CERAP to specify that a paramour is the alleged perpetrator (See Steps for Completing the Safety Assessment, Procedures 300, Appendix G).

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VI. Reference Guide - Waiver of Paramour Procedural Requirements

The information contained in this guide is to be used in conjunction with the detailed information contained in the referenced sections of these procedures. Workers must consult with their respective managers in order to obtain a waiver for those procedural requirements that may be waived.

Case Circumstances	Procedural Requirement	Waiver	
		YES	NO
Initial Investigation	Paramour Assessment Checklist		X
Paramour identified as alleged perpetrator and the allegation or allegations are unfounded at the initial stage of the investigation	Paramour Assessment Checklist		X
	Section V(a): Child victims and non-involved children interviewed without the paramour and/or parent present		X
Investigator denied access to the children by the paramour and the natural or adoptive parent	Section V(b): Referral to Law Enforcement	X	
	Section V(b): Protective Custody	X	
Formal investigation is initiated or investigation exceeds fourteen days	Section V(f)(2): Referral to Law Enforcement	X	
Children have been seriously injured	Section V(f)(3): Referral to Child Advocacy Center	X	
Pending formal investigation and child victim is under ten years of age; or has a handicapping condition; or has been seriously injured	Section V(f)(5): Weekly Monitoring Visits	X	
	Section V(f)(8): Referral for Assessment and Case Opening	X	
Indicated allegation of physical abuse involving a child that is 11 years of age or older and has no handicapping conditions and has not been seriously injured	Section V(f)(7): Referral for Assessment and Mandatory Case Opening	X	
Unfounded paramour cases that exceed 14 days	Section V(f)(10)(C): LEADS checks completed with other states where the paramour is known or alleged to have lived		X
	Section V(f)(10)(D): Risk factor added to CERAP		X
	Section V(f)(10)(A): Non-verbal alleged child victims observed and verbal alleged child victims interviewed within 72 hours prior to CPSW submitting file to supervisor for final approval	X	
	Section V(f)(10)(B): Closing Body Chart	X	

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APPENDIX I – SACWIS QUICK REFERENCE GUIDE

The following instructions are written in a two-column format. Tasks are identified in the left column (How do I?) and task instructions (Selections) or key functions are listed in the right column.

a) SACWIS BANNER MENU

Home	• Return to Desktop
Refresh	• Retrieve Fresh Data
Print	• Print Current Window
D-Net	• Access D-Net
Best Practices	• Access Best Practice Support
Help	• Get SACWIS Help
Log Out	• Close SACWIS & Save Work

b) SACWIS FUNCTIONS

Hyperlink	• Display New Window
Contraction Arrow	• Collapse Visible Data
Expansion Arrow	• View More Data
Check Box	• Select or Deselect, May Select One or More
Radio Button	• Select or Deselect, May Select Only One
Add Row Button	• Add a Row
Delete Row Button	• Delete a Row
OK Button	• Keep Data, Return to Previous Window
Cancel Button	• Return to Previous Window Without Saving Data
Save Button	• Save Data and Remain on Current Window
Date Selection Icon	• Open Calendar
Emergency or Time Sensitive Indicators	• IMMEDIATE Attention Required
Print Button	• Print Form
Group Add	• Add a Group
Single Add	• Add One
Single Delete	• Delete One
Group Delete	• Delete a Group
Closed Envelope	• Unacknowledged Assignment
Open Envelope	• Acknowledged

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c) INTAKE – CALL FLOOR WORKERS

Logging In & Out

Log Into SACWIS	<ul style="list-style-type: none"> On your Desktop double-click the SACWIS icon.
Log Out of SACWIS	<ul style="list-style-type: none"> Click Log Out button on the SACWIS Header and follow on-line instructions.

SACWIS On-Line Help

Access On-Line Help	<ul style="list-style-type: none"> Click Help at the top of your Desktop from any window. Click Contents tab. Make selection in left dialogue box, related information will default in right dialogue box.
Get Context-Sensitive Help	<ul style="list-style-type: none"> Click the Index tab. Type in the word or words to describe context desired. SACWIS will default to the context based on alpha input.
Search for a Term	<ul style="list-style-type: none"> Click Help at the top of your desktop from any window. Click the Search tab. Enter the term you are looking for. Click the Search button.
Print Help Pages	<ul style="list-style-type: none"> From the help information window, place mouse arrow in white space and right click. Click Print option from popup menu. Click Print button at bottom of popup dialogue box.

Intake Call Floor Worker Desk Top

Change Designee	<ul style="list-style-type: none"> Click the (<u>Click here to change your designee status</u>) hyperlink. Select the appropriate Name. Enter the start and end dates for the selected designated role. Click the OK button.
Change Role	<ul style="list-style-type: none"> Click the (<u>Click her to change your role</u>) hyperlink. Select the appropriate Role. Enter the start and end dates for the selected role. Click the OK button.
View Messages	<ul style="list-style-type: none"> Click the Messages expansion button.
View Call Backs	<ul style="list-style-type: none"> Click the Call Back expansion button to display your Call Backs. Click the <u>Call Back Log</u> hyperlink to access all Call Backs. Select the Call Back you want to view and click the <u>date/time</u> hyperlink.

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Intake Call Floor Worker Desk Top (Continued)

View Intakes	<ul style="list-style-type: none"> • Click the Intakes expansion button. • Select the intake you want to view and click on the Name.
View Completed Intakes	<ul style="list-style-type: none"> • Click the Completed Intakes expansion button. • Select the intake you want to view and click on the Name.
Search For a Call Back Intake Investigation Notes Person Worker	<p><i>SACWIS searches share common functions and features. Six are available from the Call Floor Worker Menu Bar.</i></p> <ul style="list-style-type: none"> • Click the Search Menu and select the desired search to access the appropriate Search Window. • On the Search Window select and/or enter available search criteria. • If you want to enter additional criteria to narrow the search, click the Down Arrow button to display additional search criteria. This can be very helpful if you receive an unwieldy number of potential matches. • Click the Perform Search button. • Access potential matches listed by clicking the hyperlink, where available. • Some searches also feature expansion buttons for viewing more details. • Click the Cancel button to end your search.

Complete a Call Back

Enter a Call Back	<ul style="list-style-type: none"> • Click the Create Menu from any window and select Call Back. • On the Call Back Details Window, enter the Reporter Group, Type, Name and Phone Number and other pertinent data and Save.
Document Call Back Attempt	<ul style="list-style-type: none"> • From either the Desktop, Callback Log or Call Back Search Windows click the date/time hyperlink to access the Call Back Details Window. • Click the [+] add button on the Call Back Details Window for a narrative entry line, enter narrative information and Save.
Complete a Call Back	<ul style="list-style-type: none"> • From either the Desktop, Call Back Log or Call Back Search Windows click the date/time hyperlink to access the Call Back Details Window. • To close the Call Back select Closed in the Status field and Save. • To create an intake click the Create Intake button.

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Initiate the Intake

Create a New Intake–In Process Window	<ul style="list-style-type: none"> Click the Create Menu from any window and select Intake or click the Create Intake button on the Call Back Details Window if there is an associated Call Back.
Perform an Intake Search	<ul style="list-style-type: none"> Enter the Name and click the Facility Checkbox, if applicable, in the Header of the Intake Window. Click the <u>Intake Search</u> hyperlink. Select and/or enter applicable search criteria. Click the Down Arrow button to display additional criteria as appropriate. Click the Perform Search button.
Complete the Intake Window Header	<ul style="list-style-type: none"> Select a radio button to indicate if it is an Assigned or Other type. Select the applicable Type from the drop-down list. Enter Name and indicate a Facility by clicking the checkbox and Save.
Enter Narrative	<ul style="list-style-type: none"> Select the number of visible lines to view from the drop-down list. Enter the Narrative in the Narrative text box and Save. <p><i>Note: The narrative may be accessed and changed/added to from any tab on the Intake Window prior to the completion of the Intake.</i></p>

General Tab

Complete the General Tab	<ul style="list-style-type: none"> Accept the current (default) dates or click the Calendar Icon to choose another. Enter incident address data and Save.
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Reporter Tab

Perform a Quick Search for a Reporter or Source	<ul style="list-style-type: none"> Click the radio button in front of the entry you are searching. Enter Type and Name fields. Click the <u>Quick Search</u> hyperlink. Results are displayed on the top of the screen.
Add Reporters, Sources and Other Persons With Information (OPWI)	<ul style="list-style-type: none"> Click the expansion button to access detailed data fields if a person is not known to SACWIS. Make the available detailed entries and Save.
Link a Reporter or Source	<ul style="list-style-type: none"> Click the <u>Click Here</u> hyperlink to access search results. If a person is a verified match, click the checkbox in front of their listing on the Link Reporter/Source Window. Click the Link button and Save.
Unlink a Reporter or Source	<ul style="list-style-type: none"> Click the Unlink button next to the listing on the Reporter Tab and Save.

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Participant Tab

Perform a Quick Search	<ul style="list-style-type: none"> Click the radio button and enter Name and available demographic data. Click the Quick Search hyperlink. The results will be displayed on top of the screen.
Link a Participant	<ul style="list-style-type: none"> Click the Click Here hyperlink in the display to access search results. Click the checkbox in front of person's listing if the person is a match. Click the Link button to link an individual and Save.
Link a Participant Group	<ul style="list-style-type: none"> Same as Link a Participant, but click the Participant Group button to view any potential people linked to this participant in SACWIS. Select individuals on the Link Participant Group Window by clicking the checkbox in both column one and two. Your selection may include any, all or none. Click the Link button after each individual selection and Save when complete.
Perform a Subsequent Oral Report (SOR) /Related Information (RI) Search	<ul style="list-style-type: none"> Same as Link a Participant Group, but click the SOR/RI button instead of the Link on the Link Participant Group Window. On the SOR/RI Window click the checkbox of the investigation you wish to link and click the appropriate command button, SOR, RI or Initial Oral Report (IOR). Linked Intakes may be unlinked on this window.
Complete Participant Information	<ul style="list-style-type: none"> Click the expansion button to access detailed data fields when the person searched is not known to SACWIS or to add information. Make the available detailed entries and Save.
View Legal Status	<ul style="list-style-type: none"> Click the expansion button to view.

Relationship Tab

Add a Relationship	<ul style="list-style-type: none"> Select one or more Adult/Both entries with the same relationship to the Kid/Both selected. Select one or more Kid/Both entries. Choose a relationship from the drop-down list. Click the Add Relationship button. Repeat as necessary and Save.
Delete a Relationship	<ul style="list-style-type: none"> Click the [-] (Delete) button next to the allegation to be deleted and Save.

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Allegation Tab

Add an Allegation	<ul style="list-style-type: none">• Select one or more Possible Perpetrators with the same allegation.• Select one or more Possible Victims.• Choose an allegation from the listing.• Click the Add Allegation button. Repeat as Necessary and Save.
Delete an Allegation	<ul style="list-style-type: none">• Click the [-] (Delete) button next to the allegation to be deleted and Save.

Deceased Tab

Select or Enter the Address Fields	<ul style="list-style-type: none">• Click the Select Address hyperlink to access addresses for this Intake.• Click to highlight the Participant and Address on the Address Window. Click the Add Address button. Click the OK button.• Repeat the process in any field you wish to add an existing address.• Click the Cancel button to return to the Deceased Tab if the address is not found. Enter the address and Save.
Print the Form	<ul style="list-style-type: none">• Click the Deceased checkbox. Click the Print Form hyperlink.

Facility Tab

Link a Facility SOR/RI	<ul style="list-style-type: none">• Enter the facility Name and Type. Click the Link Facility SOR/RI hyperlink.• Click the Perform Search button on the Link Facility SOR/RI window to search Facility Name or choose alternate or additional criteria.• Click any desired expansion buttons to view detailed information after matches are displayed.• Click the checkbox for the appropriate listing. Click the Link & RI or Link & SOR button whichever is appropriate.• Make any additional entries on the Facility Tab and Save.
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Intake Window – Decision Tab

Complete the Intake	<ul style="list-style-type: none"> • Identify any applicable characteristics by clicking the checkboxes and clicking to highlight one or more Response Indicators. • Select the applicable Response Code and Language from the drop-downs. • Complete any of the applicable processes listed below and SAVE. • Click the Send button when completed/approved.
View/Print the Intake Summary or Chicago PD Forms	<ul style="list-style-type: none"> • Click the corresponding <u>Print Form</u> hyperlink.
Create Protective Custody	<ul style="list-style-type: none"> • Click the <u>Protective Custody</u> hyperlink. • Select the child's name (one per window), PC Taker Type and other applicable selections from the drop-down lists. • Click the calendar icons to change the dates as needed. • Click the OK button when complete. Repeat for multiple children.
Create a Primary Assignment	<ul style="list-style-type: none"> • Click the <u>Create Assignment</u> hyperlink. • Select the address to be linked to the assignment form the drop-down list on the Assignment Window. Click Auto Address Search. • Select the desired Investigator from the Worker Search Window. • Click Save/Assign on the Assignment Window.
Request Approval	<ul style="list-style-type: none"> • Click the checkbox for Requires Approval.

d) INTAKE – CALL FLOOR WORKER SUPERVISORS

View Team Information	<ul style="list-style-type: none"> • To expand all listings on the desktop, click the [+] Expand All button or click individual expansion buttons to view only selected information.
View Pending Approvals	<ul style="list-style-type: none"> • Click the <u>Pending Approvals</u> hyperlink. • To make a selection from the Pending Approvals Window, click on the <u>Case Name</u> hyperlink to access the Approval Window. • On the Approval Window, select the approval decision from the drop-down and add comments, if desired, and Save.
Monitor Assignments	<ul style="list-style-type: none"> • Click the <u>Monitor Assignments</u> hyperlink. • View the pending assignments on the Assignment Monitoring Window. • Access any desired cases by clicking the <u>Case Name</u> hyperlink. • Click Cancel to return to the Desktop.

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Call Floor Worker Supervisors (Continued)

View Pending Related Information	<ul style="list-style-type: none">• Click the <u>Related Information Monitoring</u> hyperlink.• View the listings on the Related Information Monitoring Window.• Access any desired cases by clicking the <u>Case Name</u> hyperlink.• Click Cancel to return to the Desktop.
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e) INVESTIGATION WORKERS

Logging In & Out

Log Into SACWIS	<ul style="list-style-type: none">• Double-click the SACWIS icon on your Desktop.
Log Out of SACWIS	<ul style="list-style-type: none">• Click the Log Out button on the SACWIS Header. Follow on-line instructions.

SACWIS On-Line Help

Access On-Line Help	<ul style="list-style-type: none">• Click Help at the top of your desktop.• Click Contents tab.• Make selection in left dialogue box, related information will default in right dialogue box.
Get Context-Sensitive Help	<ul style="list-style-type: none">• Click the Index tab.• Type in the word or words to describe context desired.• SACWIS will default to the context based on alpha input.
Search for a Term	<ul style="list-style-type: none">• Click Help at the top of your desktop.• Click the Search tab.• Enter the term you are looking for.• Click the Search button.
Print Help Pages	<ul style="list-style-type: none">• Place mouse arrow in white space in the help information window and right click.• Click Print option from popup menu.• Click Print button at bottom of popup dialogue box.

Investigations Desk Top

Change Designee	<ul style="list-style-type: none">• Click the <u>Click her to change v0ur designee status</u> hyperlink.• Select the appropriate Name.• Enter the start and end Dates for the selected designated role.• Click the OK button.
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Investigations Desk Top (Continued)

Change Role	<ul style="list-style-type: none">• Click the <u>Click here to change your role</u> hyperlink.• Select the appropriate Role.• Enter the start and end dates for the selected role.• Click the OK button.
View Message	<ul style="list-style-type: none">• Click Messages expansion button and messages display.
View Alerts	<ul style="list-style-type: none">• Click Alerts expansion button.• Read Alert Description and Due Date fields.• Click the <u>Name</u> hyperlink to access the Investigation Window.
View Ticklers	<ul style="list-style-type: none">• Click the Ticklers expansion button.• Read the Ticklers Description and Due Date fields.• Click the <u>Name</u> hyperlink to access the Investigation Window.
Access Investigations Window	<ul style="list-style-type: none">• Click the Case Load expansion button or case load summary hyperlink.• Select the case you want to view.• Click the Investigations Window tab(s) you want to view.
View Case Load and Case Load Summary	<ul style="list-style-type: none">• Click the Case Load plus arrow or case load summary hyperlink.• Select the case you want to view and click on the <u>Name</u>.• Select tab(s) you want to view when the Investigation Window appears.
View Closed Investigations	<ul style="list-style-type: none">• Click the Closed Investigations expansion button.• Select the case want to view and click on the <u>Name</u>.
View Pending Related Information	<ul style="list-style-type: none">• Click the Pending Related Information expansion button.• Click the Intake <u>Name</u> to access the Pending Related Information Window.• Review the data.• Click the Accept button if the pending related information relates to your case.• Click the Not Appropriate button if the pending related information is not appropriate.
Acknowledge an Assignment	<ul style="list-style-type: none">• Click the Mailbox expansion button.• Click the <u>Mailbox</u> hyperlink.• Click Awaiting Acknowledgment expansion button.• Find report name that has been assigned to you.• Click <u>Report Name</u> hyperlink and acknowledgement is automatically sent.

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SACWIS Search

Search for a Person	<ul style="list-style-type: none">• Click Search at the top of your desktop.• Select Person.• Enter required data, i.e., person ID, last name, first name, etc.• Use options as needed.• Click Perform Search button.• Click various expansion buttons to review each result or click Name hyperlink to view Person Management tabs.
Search for a Worker	<ul style="list-style-type: none">• Click Search at the top of your desktop.• Select Worker.• Enter required data, i.e., person ID, last name, first name, etc.• Use options as needed (starts with or soundex, more search criteria).• Click Perform Search button.• Click various expansion buttons to review each result.
Perform a Notes Search	<ul style="list-style-type: none">• From your Desktop select the appropriate case from your case load.• Click the Name hyperlink.• Click Notes Search from any tab of the Investigation Window.• Select appropriate criteria on the Notes Search Window.• Click Perform Search button.• Select the appropriate note in the Sub Category field.• Click the hyperlink.• View notes.• Click the Print button to print note.

General Tab

Add Incident Address	<ul style="list-style-type: none">• From your desktop select the appropriate case from your case load.• Click the Name to access the Investigations Window.• Scroll to the Incident fields.• Enter the incident date in the date fields.• Enter the incident address in the address fields.• Click Save button.
Add Narrative	<ul style="list-style-type: none">• Click the New Note hyperlink from the Investigation Window.• Enter data in all appropriate fields.• Click the down arrow in the Narrative box to select the appropriate narrative.• Click Insert Text button.• Click Save.

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General Tab (Continued)

Access Linked Reports	<ul style="list-style-type: none">• From your Desktop select the appropriate case from your case load.• Click the <u>Name</u> to access the Investigations Window General tab.• Click the Linked Reports expansion button in the Linked Reports section.• View the narrative.• Click the <u>Print Document</u> hyperlink to print intake Summary.
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Person Tab

Add a New Subject	<ul style="list-style-type: none">• From your desktop select the appropriate case from your case load.• Click the <u>Name</u> to access the Investigations window.• Click the Person tab.• Click the <u>New Subject</u> hyperlink.• Enter the subject name and other available data on the New Subject Window.• Click the Search button.• Click bottom OK button if the person is found.• Click bottom Cancel button if the person is not found.• Click OK button.• The new Subject will appear in the Subjects of the Investigation field on the Person tab.• Click Save.
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Relationship Tab

Add a Relationship	<ul style="list-style-type: none">• From your desktop select the appropriate case from your case load.• Click the <u>Name</u> to access the Investigations Window.• Click the Person tab.• Click Add Relationships button.• Select the appropriate Adult and the Appropriate Kid.• Review data.• Click Save.
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Allegations Tab

Add an Allegation	<ul style="list-style-type: none">• From your desktop select the appropriate case from your case load.• Click the <u>Name</u> to access the Investigations Window.• Click the Allegations tab.• Select Possible Perpetrators(s), Possible Victim(s) and Allegations.• Click Add Allegations button.• Review data.• Click Save button.
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Check List Tab

View Contact Notes	<ul style="list-style-type: none">• From your desktop select the appropriate case from your case load.• Click the <u>Name</u> to access the Investigation Window.• Click the Check List tab.• Expand the Required Contacts section.• Select the appropriate contact and click <u>Name</u> to Access the Notes Window.• Scroll to the narrative field to view notes.
Create a New Note	<ul style="list-style-type: none">• Click the <u>New Note</u> hyperlink from the Investigation window.• Enter data in all appropriate fields.• Click the down arrow in the Narrative box to select the appropriate narrative.• Click Insert Text button.• Click Save.
Complete Note	<ul style="list-style-type: none">• Clicking the Completed button <i>will prevent the user from making changes to the note. When the investigation is approved the system will automatically set all notes to "Completed."</i>• Clicking Save will retain the note but allow the user to make changes.
Amend Note	<ul style="list-style-type: none">• Click the Amend button to enter additional information or to modify a locked note. You cannot make changes to the existing narrative. The amended note will appear at the bottom of the Narrative box.

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Facility Tab

Add a Facility	<ul style="list-style-type: none">• From your desktop select the appropriate case from your case load.• Click the <u>Name</u> to access the Investigation window.• Click the Facility tab.• Add Street and Mailing address to the appropriate fields.• If the mailing address is the same as the street address click the Same as Street Address box.• Click Save.
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Safety Assessment Tab

View Safety Assessments	<ul style="list-style-type: none">• From your desktop select the appropriate case from your case load.• Click the <u>Name</u> to access the Investigation window.• Click the Safety Assessment tab.• Click <u>Notes Search</u> to review notes associated with the Safety Assessment• Review the Approved Safety Assessment dates, names and decision.
Process a New Safety Assessment	<ul style="list-style-type: none">• Click the <u>New Safety Assessment</u> hyperlink to access the Safety Assessment window.• Review the Safety Assessment section for more details.

Decision Tab

Process Protective Custody	<ul style="list-style-type: none">• From your desktop select the appropriate case from your case load.• Click the <u>Name</u> to access the Investigation window.• Click the Decision tab.• Click <u>Create Protective Custody</u> hyperlink to access the Protective Custody window.• Add data to fields on the screen.• Enter summary narrative.• Click OK.
Process Approvals	<ul style="list-style-type: none">• From your desktop select the appropriate case from your case load.• Click the <u>Name</u> to access the Investigation window.• Click the Decision tab.• When your investigation is complete it must be submitted to your supervisor for approval. Click the <u>Submit for Approval</u> hyperlink at the bottom of the window.

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Decision Tab (Continued)

Finding Notification Request for the Custodial/Non-Custodial Parent	<ul style="list-style-type: none">• From your Desktop select the appropriate case form your case load.• Click the Name to access the Investigation window.• Click the Decision tab.• Scroll to the middle of the window.• Click the Finding Notification Request Custodial/Non-Custodial expansion button.• Select a participant.• Click Collateral Notification Document.• Complete Form Letter.• Click Print.
Requesting an Extension of Investigation Deadline	<ul style="list-style-type: none">• From your Desktop select the appropriate case from your case load.• Click the Name to access the Investigation window.• Click the Decision tab.• Click the Extension hyperlink (under Decision tab) to access the Extension window.• Click Add Extension button• Enter the request date for the extension.• Enter reason for extension request.• Enter explanation for request for extension in CPS Workers Extension box.• Click Submit for Approval button.

Safety Assessment

Complete a New Safety Assessment	<ul style="list-style-type: none">• From your Desktop select the appropriate case from your case load.• Click the Name to access the Investigation window.• Click the Safety Assessment tab.• Click the New Safety Assessment hyperlink to access the Safety Assessment window.• Access each tab on the window and complete all appropriate fields.
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Milestone Tab

Complete a CERAP	<p>In the When to Complete the form field click the For Child Protection radio button.</p> <p>Select the appropriate 1-4 statement by clicking the radio button.</p> <p>Click Save.</p> <p>Proceed through the other Safety Assessment Window tabs.</p>
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Case Members

Include/Exclude Case Members	<ul style="list-style-type: none">• From your Desktop select the appropriate case from your case load.• Click the <u>Name</u> to access the Investigation window.• Click the Safety Assessment tab.• Click the <u>New Safety Assessment</u> hyperlink to access the Safety Assessment Window.• Click the Case Members tab.• To include all participants in the assessment click the >> button.• To include a specific participant click in the box next to the participant's name and click the > button.• To exclude a specific participant click in the box next to the participant's name and click the < button.• To exclude all participants click the << button.• Review results.• Click Save if correct.
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Safety Factors

Record Factors to Assess a Child's Safety	<ul style="list-style-type: none">• From your Desktop select the appropriate case from your case load.• Click the <u>Name</u> to access the investigation window.• Click the Safety Assessment tab.• Click the <u>New Safety Assessment</u> hyperlink to access the Safety Assessment Window.• Click the Yes or No radio button for each of the 15 statements.• If Yes is selected enter the Safety Factor Description and Family Strengths/Mitigation Circumstances in the appropriate boxes.• Review your responses.• Click Save.• Error messages will display if any responses were not given.• Read the messages and correct any missed responses.• Click Save again.
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Safety Decision

Record a Safety Decision	<ul style="list-style-type: none">• From your Desktop select the appropriate case from your case load.• Click the Name to access the Investigation window.• Click the Safety Assessment tab.• Click the New Safety Assessment hyperlink to access the Safety Assessment window.• Click the Safety Decision tab to view results.
Record Narrative if a Child is found to be Safe	<ul style="list-style-type: none">• If the child is safe; enter your narrative explaining why you believe the child is not likely to be in immediate danger.• Review your narrative.• Click Save.• Submit to your supervisor by clicking the Submit for Approval button.

Safety Plan

Record Safety Plan for Children Found to be Unsafe	<ul style="list-style-type: none">• From your Desktop select the appropriate case from your case load.• Click the Name to access the Investigation window.• Click the Safety Assessment tab.• Click the New Safety Assessment hyperlink to access the Safety Assessment Window.• Click the Safety Plan tab.• Enter your response to all seven questions.• Check the Signature on file for Parent(s)/Caretakers(s) box if the signature is in the case file.• Check the Signature on file for Person Responsible for carrying out Safety Plan if the signature is on file.• Review responses.• Click Save button.
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Basics Tab

View/Change Person Information	<ul style="list-style-type: none">• From your Desktop select the appropriate case from your case load.• Click the Name to access the Investigation Window.• Click the Person tab.• Click the Name of the subject to access the Person Management Window.• Enter all available personal data in the appropriate fields and/or correct any existing entries.• Review responses.• Click Save button.
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Address Tab

Search for an Address or Add an Address	<p><i>TO SEARCH FOR AN ADDRESS</i></p> <ul style="list-style-type: none">• To search for an address from your Desktop select the appropriate case from your case load.• Click the <u>Name</u> to access the Investigations window.• Click the Person tab.• Click the <u>Name</u> of the subject to access the Person Management Window.• Click the Address tab.• Click the expansion button to view all address types for the subject. <p><i>TO ADD AN ADDRESS</i></p> <ul style="list-style-type: none">• Select the appropriate address type.• Enter the address in the appropriate fields.• Click the Primary box if the address is the primary residence for the subject.• Review entries.• Click Save button.
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Also Known As (AKA) Tab

Add an AKA	<ul style="list-style-type: none">• From your Desktop select the appropriate case from your case load.• Click the <u>Name</u> to access the Investigations window• Click the Person tab.• Click the <u>Name</u> of the subject to access the Person Management Window.• Click the AKA tab.• Click the “Add a text line” button• Click the Arrow to select the appropriate AKA type.• Click the Arrow to select the appropriate Prefix if indicated.• Enter the Last, First and Middle Names.• Enter Suffix if subject is a JR, Sr and III etc.• Review entries• Click Save button.
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Deceased Tab

Add/View Deceased Information	<ul style="list-style-type: none">• From your Desktop select the appropriate case from your case load.• Click the <u>Name</u> to access the Investigations window.• Click the Person tab.• Click the <u>Name</u> of the subject to access the Person Management Window.• Click the Deceased tab.• Review all fields if the decedents data was previously entered.• To add a record, enter data in the appropriate fields.• Review entries.• Click Save button.
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Law Enforcement Agencies Data System (LEADS) Check Tab

Record LEADS Check Results	<ul style="list-style-type: none">• From your Desktop select the appropriate case from your case load.• Click the <u>Name</u> to access the Investigations window.• Click the Person tab.• Click the <u>Name</u> of the subject to access the Person Management window.• Click the LEADS Check tab.• To view all data click all expansion buttons.• To add new information enter data in appropriate fields.• Review entries.• Click Save button.
Cancel LEADS Check	If the data entered is incorrect and you don't want to save it click Cancel button

f) INVESTIGATION SUPERVISOR'S DESKTOP

Change a Designee	<ul style="list-style-type: none">• Click <u>Click here to change your designee status</u> to access the Designee Selection Window.• Select the appropriate name.• Enter the start and end dates for the elected designated role.• Review selections.• Click OK.
View Team Members	<ul style="list-style-type: none">• Click Team Members expansion arrow to access the team members.• Select the team member to view Case Load, Closed Investigations and Pending Related Information.

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Investigation Supervisor's Desktop (Continued)

View Team Members' Unacknowledged Investigations	<ul style="list-style-type: none">• Click Team Members expansion arrow to access the team members.• Select the team member to view Case Load.• Click the Case Load expansion button to view Unacknowledged Investigations.
Complete an Assignment from the Mailbox	<ul style="list-style-type: none">• Click Mailbox expansion button.• Click <u>Mailbox Number</u> hyperlink.• Click Team drop down menu arrow and select a team.• Click <u>Team Summary</u> hyperlink.• Select team member by clicking appropriate radio button.• Click OK.• Select report name by clicking the check box.• Click Send to assign the report.

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PROCEDURES 300.APPENDIX J - DOMESTIC VIOLENCE

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- a) Purpose
- b) Definitions
- c) Domestic Violence Research Findings
- d) Identifying Signs and Symptoms of Domestic Violence
 - 1) Signs and Symptoms Directly Related to an Incident of Domestic Violence
 - 2) External and Significant Indicators of Domestic Violence
- e) Assessing Safety and Risk Related to Domestic Violence
- f) Domestic Violence Interviews
- g) Clinical Services Support
- h) Staff Safety
- i) Documentation

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a) Purpose

The purpose of this Appendix is to acquaint Child Protection Specialists and Supervisors with issues and concerns unique to how domestic violence affects children and families. The Appendix is also intended to provide guidance for addressing domestic violence within the context of a child abuse or neglect investigation.

b) Definitions

While it is imperative when working with families that experience domestic violence to understand the significant impact domestic violence has on children, it is equally significant to understand the language and resources used to identify and to protect the children. These definitions will aid Department investigative staff and supervisors in recognizing signs, symptoms and resources for domestic violence when assessing for risk and safety as well as intervening with families where domestic violence appears to be evident.

The Illinois Domestic Violence Act of 1986 [750 ILCS 60] defines domestic violence as a crime in which physical abuse, harassment, intimidation of a dependent, interference with personal liberty or willful deprivation is perpetrated by one family or household member against another.

"Abuse" means physical abuse, harassment, intimidation of a dependent, interference with personal liberty or willful deprivation but does not include reasonable direction of a minor child by a parent or person in loco parentis. [750 ILCS 60/103(1)]

"Abused Child" means a child whose parent or immediate family member, or any person responsible for the child's welfare, or any individual residing in the same home as the child, or paramour of the child's parent:

inflicts, causes to be inflicted, or allows to be inflicted upon such child physical injury, by other than accidental means, which causes death, disfigurement, impairment of physical or emotional health, or loss or impairment of any bodily function;

creates a substantial risk of physical injury to such child by other than accidental means which would be likely to cause death, disfigurement, impairment of physical or emotional health, or loss of or impairment of any bodily function;

commits or allows to be committed any sex offense against such child, as such sex offenses are defined in the Criminal Code of 2012 or in the Wrongs to Children Act, and extending those definitions of sex offenses to include children under 18 years of age;

commits or allows to be committed an act or acts of torture upon such child;

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inflicts excessive corporal punishment;

commits or allows to be committed the offense of female genital mutilation, as defined in Section 12-34 of the Criminal Code of 2012, against the child;

causes to be sold, transferred, distributed, or given to such child under 18 years of age, a controlled substance as defined in Section 102 of the Illinois Controlled Substances Act in violation of Article IV of the Illinois Controlled Substances Act or in violation of the Methamphetamine Control and Community Protection Act, except for controlled substances that are prescribed in accordance with Article III of the Illinois Controlled Substances Act and are dispensed to such child in a manner that substantially complies with the prescription; or

commits or allows to be committed the offense of involuntary servitude, involuntary sexual servitude of a minor, or trafficking in persons as defined in Section 10-9 of the Criminal Code of 2012 against the child.

A child shall not be considered abused for the sole reason that the child has been relinquished in accordance with the Abandoned Newborn Infant Protection Act.

[325 ILCS 5/3]

”Domestic Violence” may be used synonymously with the term “abused” as defined above, outside of the Department. However, Illinois Domestic Violence Act recognizes domestic violence as a serious crime against the individual and society which produces family disharmony, promotes a pattern of escalating violence which frequently culminates in intra-family homicide, and creates an emotional atmosphere that is not conducive to healthy childhood development; it also recognizes domestic violence against high risk adults with disabilities, who are particularly vulnerable due to impairments in ability to seek or obtain protection, as a serious problem which takes on many forms, including physical abuse, sexual abuse, neglect, and exploitation, and facilitate accessibility of remedies under the [Illinois Domestic Violence] Act in order to provide immediate and effective assistance and protection. (See Sections 102 and 103 of Illinois Domestic Violence Act of 1986 [750 ILCS 60].)

"Exploitation" means the illegal, including tortious, use of a high-risk adult with disabilities or of the assets or resources of a high-risk adult with disabilities. Exploitation includes, but is not limited to, the misappropriation of assets or resources of a high-risk adult with disabilities by undue influence, by breach of a fiduciary relationship, by fraud, deception, or extortion, or the use of such assets or resources in a manner contrary to law. [750 ILCS 60/103(5)]

“Family or household members” include spouses, former spouses, parents, children stepchildren and other persons related by blood or by present or prior marriage, persons who share or formerly shared a common dwelling, persons who have or allegedly have a child in common, persons who shared or allegedly share a blood relationship through a child, persons who have or have had a dating or engagement relationship, persons with

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disabilities and their personal assistants and caregivers as defined in paragraph (3) of subsection (b) of Section 12-21 of the Criminal Code of 1961.

"Harassment" means knowing conduct which is not necessary to accomplish a purpose that is reasonable under the circumstances; would cause a reasonable person emotional distress; and does cause emotional distress to the petitioner. Unless the presumption is rebutted by a preponderance of the evidence, the following types of conduct shall be presumed to cause emotional distress:

creating a disturbance at a petitioner's place of employment or school;

repeatedly telephoning petitioner's place of employment, home or residence;

repeatedly following petitioners about in a public place or places;

repeatedly keeping petitioner under surveillance by remaining present outside her or his home, school, place of employment, vehicle or other place occupied by petitioner or peering in petitioner's windows;

improperly concealing a minor child from petitioner, repeatedly threatening to improperly remove a minor child of the petitioner's from the jurisdiction or from the physical care of petitioner, repeatedly threatening to conceal a minor child from the petitioner, or making a single such threat following an actual or attempted improper removal or concealment, unless respondent was fleeing an incident or pattern of domestic violence; or

threatening physical force, confinement or restraint on one or more occasions.
[750 ILCS 60/103(7)]

"Interference with personal liberty" means committing or threatening physical abuse, harassment, intimidation or willful deprivation so as to compel another to engage in conduct from which she or he has a right to abstain or refrain from conduct in which she or he has a right to engage. [750 ILCS 60/103(9)]

"Intimidation of a dependent" means subjecting a person who is dependent because of age, health or disability to participation in or the witnessing of: physical force against another or physical confinement or restraint of another which constitutes physical abuse as defined in [the Illinois Domestic Violence] Act, regardless of whether the abused person is family or household member. [750 ILCS 60/103(10)]

"Order of protection" means an emergency order, interim order or plenary order, granted pursuant to [the Illinois Domestic Violence] Act, which includes any or all of the remedies authorized by Section 214 of this Act. [750 ILCS 60/103 (12)]

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"Physical abuse" includes sexual abuse and means any of the following:

knowing or reckless use of physical force, confinement or restraint;

knowing, repeated and unnecessary sleep deprivation; or

knowing or reckless conduct which creates an immediate risk of physical harm.

[750 ILCS 60/103(14)]

"Stay away" means for the respondent (subject of an order of protection) to refrain from both physical presence and nonphysical contact with the petitioner whether direct, indirect (including, but not limited to, telephone calls, mail, email, faxes, and written notes), or through third parties who may or may not know about the order of protection. [750 ILCS 60/103 (14.5)]

"Strangulation" means intentionally impeding the normal breathing or circulation of the blood of an individual by applying pressure on the throat or neck of the individual or by blocking the nose or mouth of that individual.

"Willful deprivation" means wilfully denying a person who because of age, health or disability requires medication, medical care, shelter, accessible shelter or services, food, therapeutic device, or other physical assistance, and thereby exposing that person to the risk of physical, mental or emotional harm, except with regard to medical care or treatment when the dependent person has expressed an intent to forgo such medical care or treatment. [750 ILCS 60/103(15)]

c) **Domestic Violence Research Findings**

- 1) Research shows that domestic violence perpetrators do not only victimize adults. Adult domestic violence and child maltreatment are often co-occurring. Research examining the intersection of child maltreatment and domestic violence shows:
 - A) Domestic violence is present in 30 to 60 % of child welfare cases. (Appel et al, 1998; Edleson, 1999)
 - B) Domestic violence is considered a major risk factor for fatal child abuse. (National Center for Fatality Review and Prevention, 2019)
 - C) A substantial number of female caregivers in families referred to child protective services have experienced physical violence perpetrated by an intimate partner. (Hazen et al., 2004)
 - D) Among children who have witnessed domestic violence, over half (56.8%) have also experienced one or more forms of maltreatment. (Hamby et al., 2010)

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- E) Perpetrators often use their children to control, intimidate and keep track of their partners. (Beeble et al., 2007)

- 2) Children are uniquely impacted by domestic violence. Some children may experience trauma from observing and hearing their caregivers being abused, which can lead to children exhibiting higher levels of childhood behavioral, social and emotional problems than would children who have not witnessed such violence. When children are secondary victims, research shows that exposure to trauma increases the risk of:
 - A) Eating and sleep disorders;
 - B) Verbally and physically aggressive behaviors;
 - C) Feelings of guilt, when the children believe that they are the cause of the abuse;
 - D) Poor academic performance;
 - E) Becoming easily frightened, anxious, clingy or frequent crying if the children are under the age of five;
 - F) Adolescent alcohol and drug abuse; or
 - G) Teen dating violence (Research shows that youth ages 16 – 24 are most at risk of domestic violence than any other age group.

d) **Identifying Signs and Symptoms of Domestic Violence**

The ability to recognize signs and symptoms of domestic violence is possible through knowledge and understanding of language and behaviors associated with domestic violence incidents. The signs and symptoms of domestic violence may be plentiful or they may be discrete and subtle. Some signs may be observable either directly or indirectly as it relates to a single or repetitive incident of domestic violence. Indicators identified directly or indirectly to a given report or investigation do not measure the significance of the information learned. External signs of domestic violence are as significant as those directly learned in reference to a specific incident or situation. This section discusses the language and behaviors demonstrated by domestic violence victims, perpetrators and those closely related to the families living with domestic violence. Recognition of these cues will enable Child Protection Specialists and Supervisors to focus decision-making on the level of interventions necessary to assure the safety of children.

- 1) **Signs and Symptoms Directly Related to an Incident of Domestic Violence.** Where domestic violence is suspected or reported as present, there are some very telling signs and symptoms that should be considered significant indicators (as

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outlined in the Domestic Violence Screen) of risk of harm or a safety concern for children and the families they are a part of. The following is a list of factors that are often directly related to incidents of domestic violence. It is important to note that victims live these experiences from day to day and may consider them normal routine activities, and an outsider will see the risk that they don't see, and recognize the significance in patterns (such as those listed below) that would otherwise be communicated by the victim as minimal.

- A) A child is injured as a result of a domestic violence incident;
- B) The batterer struck the adult victim while victim was holding a child;
- C) The child is at risk of harm and/or injured while trying to intervene in an incident of domestic violence;
- D) Weapon(s) are used or brandished in a domestic violence assault;
- E) Substance misuse contributed to a domestic violence incident;
- F) Adult victim experienced physical injury such as bruises, cuts, black eyes, strangulation marks on the neck or hospitalization resulting from an incident of domestic violence;
- G) Adult victim is experiencing or has experienced domestic violence while pregnant;
- H) Incident involved strangulation, or attempted strangulation of an adult or child victim;
- I) Batterer has made death threats or threats of serious injury;
- J) Batterer has stalked or harassed adult victim and children;
- K) Batterer has committed sexual assault of adult victim;
- L) There are multiple family stressors (e.g., unresolved grief, prior or concurrent involvement with the Department, unemployment, legal issues);
- M) The presence of underlying conditions (e.g., mental health, substance misuse and developmental disabilities);
- N) The batterer's whereabouts are unknown;
- O) There are frequent, chronic domestic violence incidents;
- P) The adult victim and children have significant fear of the batterer; or
- Q) The adult victim and children have no plan for protection from domestic violence.

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- 2) **External and Significant Indicators of Domestic Violence.** External indicators of domestic violence, while not always evident in the initial visits with a family, often appear as the investigation continues. Throughout the life of the investigation, the child protection specialist must continue to avidly assess for external and significant indicators of domestic violence. External indicators may be observed directly by the Child Protection Specialist or reported by a non-household member, a mandated reporter, or reported directly by another household member about past or recent incidents. These indicators may be documented in third-party reports such as medical records, police reports, or documented orders of protection. Such reporting can provide insight into patterns and frequency of incidents of domestic violence that a family experience. The list below highlights factors that are significant indicators of domestic violence. It is important to know these markers may be minimized by both reporters and household members based on their individual history of domestic violence and abuse. However, these factors should be considered when assessing safety concerns and risk of harm for children during an investigation, and should be considered in the determination of an investigation outcome, especially where the primary caregiver does not demonstrate the ability to protect the children.

The external and significant indicators discussed in this Appendix should help Child Protection Investigators identify possible domestic violence issues during abuse or neglect investigations. The presence of these external and significant indicators demonstrate that domestic violence is an underlying condition in the family, and should be considered when assessing safety concerns and risk of harm.

- A) There are frequent, domestic violence incidents involving any member of the family group;
- B) Adult victim has a history of serious injury;
- C) Third party or collateral reports of domestic violence;
- D) Criminal history of assault or damage to property that has been verified through LEADS;
- E) One partner seems to control everything (e.g., answers questions for the other partner, discourages individual interviews, monopolizes the attention of the worker, silent but uses non-verbal cues to communicate);
- F) Observed damage to the home (e.g., phone ripped from the wall, holes in the walls, broken doors or furniture);
- G) Any self-reported incident of domestic violence;

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- H) One partner uses the children to control what the other partner says, does or thinks;
- I) Prior or current police involvement for domestic violence;
- J) Prior or current domestic violence order of protection; or
- K) A history of receiving domestic violence services.

e) Assessing Safety and Risk Related to Domestic Violence

- 1) Assessing the severity of the situation and events the family experiences is a concurrent process with interviewing each family member. Assessing for safety and risk must occur throughout the life of the investigation. However, the presence of domestic violence may or may not warrant Department intervention. The Child Protection Specialist must refer to the Child Endangerment Risk Assessment Protocol (CERAP) and the Allegation System to determine if the domestic violence in the child's life rises to the level of abuse or neglect, or poses a threat to the child.
- 2) The Child Protection Specialist shall identify and assess any and all strategies the adult victim as used in the past that can be supported or strengthened to protect the children. The Child Protection Specialist shall also identify and document whether any of the following protective factors from the Strengthening Families Initiative are present between the non-offending caregiver and children. In 2004, Strengthening Families Illinois (SFI) began as an early childhood primary prevention collaboration convened by the Illinois Department of Children and Family Services (IDCFS) through a contract with a fiscal agent, Family Focus Inc. In Strengthening Families™ is a research-informed approach to increase family strengths, enhance child development and reduce the likelihood of child abuse and neglect. It is based on engaging families, programs and communities in building five protective factors:
 - A) parental resilience;
 - B) social connections;
 - C) knowledge of parenting and child development;
 - D) concrete support (i.e., food, shelter, clothing, health care); and/or
 - E) social and emotional competence

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- 3) Protective factors support child safety, wellbeing and healing amidst the risk factor of domestic violence (Holmes et al, 2021) and due to protective factors, approximately 40% of children who have been exposed to domestic violence fare just as well as, or better than, children not exposed. (Holmes et al, 2003)
- 4) For additional information regarding protective factors in domestic violence cases, Child Protection Specialists should consult with a Clinical Domestic Violence Specialist in the Division of Clinical Services' Domestic Violence Intervention Program. To request a consultation, the Child Protection Specialists shall send a **CFS 399-1, Clinical Service Referral Form** to DCFS.ClinicalRef@illinois.gov.

f) Domestic Violence Interviews

- 1) Family and collateral contact interviews are critical to identifying and assessing safety concerns and risk of harm for children when domestic violence is a factor. Interviews can be challenging at times, because the questions can appear invasive and uncomfortable for both the family members, collaterals and the interviewer. However, the information needed to assess families living with reported or suspected incidents of domestic violence serve three purposes. First, thorough information gathering aides an investigator in determining if there is a current or past incident of domestic violence. Second, proper questioning can inform an investigator of the frequency and severity of domestic violence incidents. Third, information gathered from interviews aides the investigator and supervisor in the assessment of the caregiver's ability to mitigate the situation and ability to protect the children.
- 2) Abusers do not come in a prescribed role. An abuser could hold the role of primary caregiver, current paramour or spouse, or former paramour or spouse. In the discussion in these subsections 1 through 10 (below), the primary caregiver will be referenced as the likely adult victim where domestic violence is occurring.

A) Interviewing the Primary Caregiver or Adult Victim.

- i) An effective interview with an adult victim should inform the interviewer or Child Protection Specialist of the level of risk to the children and the caregiver. It should also reveal the impact that domestic violence is having on the children.
- ii) Due to factors such as denial and minimization, some adult victims of DV may not be able to comprehend or understand the impact of exposure to violence on children. Some victims may also perceive the DV in their intimate relationship as normal, and as a result, be unable to identify dynamics of power and control that they have experienced, or recognize that these dynamics are indicative of DV.

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- iii) In turn, some victims of DV may be very well aware of the intimate partner violence they are experiencing, but may also be facing barriers to accessing services or being able to safely leave the abusive relationship. This makes the need to ask questions regarding the children's safety a must. This is best accomplished when the interviewer or Child Protection Specialist takes care to establish a rapport with the adult victim immediately.
- iv) Rapport is crucial when interviewing domestic violence victims and their children because victims are often apprehensive about disclosing and discussing incidents of domestic violence. The adult victim of domestic violence may never have told anyone about the abuse and/or may be very fearful that disclosing the abuse will put herself and her children in danger.
- v) Explain that the interviewer or Child Protection Specialist cannot grant anyone full disclosure of information that is essential for case planning, service delivery, court actions or Administrative Hearings, and that the interviewer or Child Protection Specialist will work with the adult victim to plan for their safety and the safety of their children. Assure the adult victim that the interviewer or Child Protection Specialist are concerned about their safety, as well as the safety of their children.
- vi) When domestic violence is suspected as a family dynamic, interviews must be conducted with the adult victim away from the alleged perpetrator. The interviewer or Child Protection Specialist must listen carefully to the responses to get a sense of the relationship between the adult victim and the alleged perpetrator.

B) Identifying the Presence of Domestic Violence when Interviewing the Primary Caregiver or Adult Victim.

- i) In addition to the screening questions for identifying the presence of verbal and/or significant indicators, the statements and questions below are effective for gaining insight into what is going on in the relationship of an adult victim of domestic violence. These talking points will help to facilitate the disclosure and identification of significant indicators of risk:
 - a) Tell me about your relationship.
 - b) How are decisions made in your relationship?
 - c) How are disagreements resolved in your relationship?
 - d) Do you feel free to do, think or believe what you want?
 - e) Do you believe your partner respects you as a person?

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- f) Does your partner ever act jealous or possessive?
 - g) Have you ever felt afraid of your partner?
 - h) Have you ever been afraid for your safety or the safety of your children because of the behavior of your partner?
- ii) In reports where an adult victim provides false or incomplete information to professionals due to well-founded fears about the consequences of disclosure to her safety and the safety of her children, corroboration of credible information from other sources is important. That information may be obtained from collateral contacts, LEADS, law enforcement records, medical records, etc.
- C) **Assessing the Severity of Domestic Violence Incidents Through Interviewing a Primary Caregiver or Adult Victim.**
- i) Effective interviewing is not just about having the correct questions to ask, but about having the answers to the questions that provide evidence to support a conclusion. An interviewer or Child Protection Specialist who has established a rapport with the adult victim and employs effective questioning, active listening and effective note taking is more likely to gain the answers to the questions.
 - ii) Answers to the questions below will help identify the perpetrator's level of power and control over the family, any patterns of domestic violence, and uncover the various forms domestic violence including physical, emotional, mental, social and financial abuse.
 - a) Has the spouse/paramour ever tried to control what the adult victim says and does (e.g., keep them away from their family, friends or neighbors, prevented them from going to work, listened to their phone calls, followed them, controlled their income or how they spend their money)?
 - b) Has the spouse/paramour ever tried to control or limit the adult victims contact with others (e.g., keep them away from their family, friends or neighbors, prevented them from going to work, listened to their phone calls, or followed them)?
 - c) Has the spouse/paramour ever acted in a way that hurt or frightened the adult victim (e.g., threatened to do something harmful, behaved violently in public, forced them to engage in sexual activity, called them degrading names)?

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- d) Has the spouse/paramour ever strangled (choked) the adult victim or attempted to do so?

Note: Victims often refer to strangulation as having been choked (e.g., placed a loose or firm object around the neck with pressure, pinned them down, by the neck to the floor, wall or bed with a body part such as arm, elbow or foot).

- e) Has the spouse/paramour ever pushed, slapped, punched, kicked or hurt the adult victim in other ways (e.g., any physical harm or restraint)?

- f) Have the children been exposed to incidents of domestic violence (e.g., seen or heard the abuse)?

- g) Has the spouse/paramour ever called the adult victim derogatory or harsh names, ridiculed them or put them down verbally? Has the spouse/paramour ever done so in front of the children or told the children what was said in order to demean the adult victim?

- h) Has the spouse/paramour ever threatened to use the children to control the adult victim in any way (e.g., forced the children to participate in the abuse or watch the adult victim being abused, blamed the children for the abuse)?

- i) Has the spouse/paramour threatened to use a weapon or actually used a weapon to intimidate or physically cause harm to the adult victim or their children?

- j) Has the spouse/paramour threatened to kill the adult victim or their children, or caused harm to their pets?

- k) Has the spouse/paramour ever engaged in reckless behavior (e.g., drove too fast with the adult victim and the children in the car)?

- l) Has the spouse/paramour forced the adult victim to perform sexual acts that make them feel uncomfortable, prevented them from using birth control, withheld sex, caused them harm during pregnancy; forced them to engage in prostitution or pornography?

- m) Has the spouse/paramour forced the adult victim to use, sell or buy drugs?

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D) **Assessing Concerns of Risk and Safety While Interviewing a Primary Caregiver or Adult Victim.**

- i) The information needed to assess the family is not limited to the experiences of the adult victim, but also about how the adult victim perceives the experiences of their children. The questions below will help the interviewer or Child Protection Specialist to assess the level of risk to the children.
 - a) Has the adult victim been concerned with how the spouse/paramour behaves toward the children?
 - b) When the adult victim speaks on behalf of the children, how does the spouse/paramour respond?
 - c) Has the spouse/paramour threatened to take the children, called or threatened to call DCFS or accused the adult victim of being an unfit parent?
 - d) Has the spouse/paramour threatened to hurt or kill the children?
 - e) Has the spouse/paramour caused harm to the adult victim in front of the children, or hit a child with a belt, strap or other objects?
 - f) Has the spouse/paramour touched a child of the adult victim in a way that made the child feel uncomfortable?
 - g) Has the spouse/paramour assaulted the adult victim while they were holding the child?
 - h) Has the spouse/paramour asked a child of the adult victim to tell him or her what the adult victim is doing during the day, treated one child significantly different from another or forced any of the adult victim's children to participate in or watch the occurrence of abuse of the adult victim?
- ii) If a Child Protection Specialist suspects domestic violence is occurring, the Child Protection Specialist might ask the adult victim directly about the experience of their children, such as have any of your children:
 - a) Overheard the yelling and/or violence?
 - b) Behaved in ways that remind the adult victim of their partner?
 - c) Physically hurt the adult victim or other family members?
 - d) Tried to protect the adult victim?
 - e) Tried to stop the violence?
 - f) Intentionally self-injured?
 - g) Been fearful of leaving the adult victim alone?
 - h) Had problems at home, school or day care, such as aggressiveness, violent behaviors, bed-wetting, sleeping problems, nightmares, etc.?

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iii) Additional questions for consideration:

- a) How dangerous does the adult victim think their partner is?
- b) What acts of domestic violence does the adult victim believe their partner is capable of inflicting on them or their child?
- c) Does the adult victim have any current injuries or health problems?
- d) How has this relationship affected how the adult victim feels about themselves, their children, the future?
- e) How does the adult victim explain the violence to themselves?
- f) How does the adult victim believe their children understand the violence?
- g) What action(s) does the adult victim believe would help keep themselves and/or their children safe?

E) **Assessing the Primary Caregiver's or Adult Victim's Ability to Mitigate Safety Concerns and Risk of Harm.** Seeking help can be a difficult task for parents and caregivers living with domestic violence. Evidence of a parent or caregiver seeking assistance to escape domestic violence should be regarded as a strength to build upon to ensure the safety of the children involved. These questions can help the Child Protection Specialist in determining the family's history of seeking help or intervention.

- i) Has the adult victim sought help or intervention in the past and if so what happened? Has the adult victim told anyone about the abuse?
- ii) Has the adult victim seen a counselor and/or left home as a result of, domestic violence? If you left home, where did the adult victim go and did they take their children with them?
- iii) Has the adult victim called the police, made a criminal complaint, filed for an order of protection or utilized the services of a domestic violence agency or shelter?
- iv) Has the adult victim ever tried to fight back?

F) **Interviewing Child Victims Living with Domestic Violence.**

- i) Interviewing children is critical to determine such things as the presence and frequency of domestic violence, and the intensity or severity of incidence of domestic violence that has or is occurring. Child Protection Specialists should use language the children understand when interviewing, and like adult victims, children should be interviewed individually where possible. Younger children may be interviewed together if they are most comfortable with a second member of the family present. Children should not

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be interviewed in the presence of anyone who can intimidate them, whether an adult or sibling. Suggested questions for children are divided into the three categories below:

- a) Child's account of what he/she saw and/or heard:
 - 1) "What kind of things do you see or hear mom and dad (or name of paramour) fight about?"
 - 2) "What happens when they fight: Have you ever seen or heard them yell at each other? Have you ever seen them hit each other?"
 - 3) "Have you ever seen either your mom or dad (or name of paramour) get hurt?"
 - 4) "Have you ever seen the police come to your house when mom and dad (or name of paramour) fight?"
 - 5) "Have you ever gotten hit or hurt when mom and dad (or name of paramour) were fighting?"

 - b) Impact of witnessing the violence:
 - 1) "How do you feel about your mom and dad (or name of paramour) fighting?"
 - 2) "Do you think a lot about your mom and dad (or name of paramour) fighting? (For example, when you're in school or while you're playing?)"
 - 3) "Do you ever have trouble sleeping at night or have a nightmare?"

 - c) Child's concerns about safety:
 - 1) "What do you do when your mom (or name of paramour) are fighting? (For example, stay in the room, go to an older sibling, leave or hide, ask parents to stop, call someone, run out, get someone to help?)"
 - 2) "When your mom and dad (or name of paramour) are fighting, what do you worry about the most?"
 - 3) "Have you ever talked to any other grown-ups about your mom and dad (or name of paramour) fighting?"
- ii) These questions for children are not all-inclusive. Each question may require or lead to additional, follow-up questioning.
- iii) The Child Protection Specialist should consider requesting the assistance of the local Child Advocacy Center (CAC) to interview children in investigations where there is chronic violence in the home and parents have failed in the past to cooperate with services.

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G) **Assessing the Level of Risk or Safety While Interviewing a Minor.**

- i) The Child Protection Specialist should take into consideration that children may react differently to violence in the home. Children may externalize or internalize trauma. There is no single indicator to determine abuse. For instance, a child that does not flinch when the alleged abuser raises their hand or who appears to love an alleged abuser is not an indicator that the child has not been abused. Similarly, the fact that an alleged adult victim seems to be comfortable speaking in front of the alleged abuser is not an indicator of absence of domestic violence in the home.
- ii) When assessing the level of risk to the children, the Child Protection Specialist should consider whether there is reasonable cause to believe:
 - a) There is ongoing domestic violence and/or that the alleged perpetrator has a history of domestic violence;
 - b) The children have been or are likely to be used as a shield, or held or physically restrained from leaving during an incident of domestic violence;
 - c) The children will be placed at substantial risk of harm should they attempt to intervene during an incident of domestic violence;
 - d) The alleged perpetrator has committed assault or murder and has threatened to harm members of the immediate family, extended family and/or pets;
 - e) The ability of the child or children to function on a daily basis has been substantially impaired due to incidents of domestic violence;
 - f) The non-offending caregiver or alleged perpetrator describe the children in negative terms, act negatively towards the children or blame them for the incidents of domestic violence; and/or
 - g) The alleged batterer has used or has threatened to use weapons in an act of violence.
 - h) The domestic violence in the family is directly compromising the adult victim's ability to protect the children.

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H) Interviewing Persons Who Use Violence and Coercive Control.

- i) Those who use violence and coercive control are unique and do not present uniformly. Some may appear harmless to outsider observers; in fact, they may appear charming or mild-mannered to those outside of their household. Some may reveal their use of violence and coercive control through their language, behavior and interactions. While reviewing information contained in reports assess for the following indicators which are common characteristics of a batterers profile:
 - a) Constant blaming of everyone but themselves;
 - b) Obsessive behavior (e.g., jealous, possessive, accusatory);
 - c) Threatening (e.g., suicide, violence, kidnapping, harming those who attempt to help);
 - d) Stalking;
 - e) Presents as the victim (e.g., tries to convince the Child Protection Specialist that they are the real victim);
 - f) Vengeful (e.g., files an order of protection against the victim);
 - g) Powerful (may be in a position of power or report having friends in positions of power through wealth, organized crime or professions such as law enforcement);
 - h) Paranoid/hypersensitive;
 - i) Criminal record of violent offenses (refer to LEADS check); or
 - j) Belligerent toward authority figures, which may include the Child Protection Specialist. However, the batterer may display the opposite behavior and act harmless and even compliant to outsiders.
- ii) The questions below can be effective talking points and interview questions for alleged perpetrators:
 - a) Tell me about your relationship.
 - b) Tell me three things you like about your partner and family.

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- c) How does your family handle conflict?
 - d) What kinds of things do you expect from your partner/family?
 - e) What do you do when you don't get your own way?
 - f) Have you ever wanted to physically hurt someone?
 - g) Have you ever forcefully touched anyone in your family? In what manner?
 - h) Have you ever been told that you have a problem with violence? If "yes", who told you?
- iii) **Do not confront the batterer with statements made by the adult victim or children.** Doing so will place the adult victim and children at increased risk of harm. When referring to the batterer's behavior, use third party reports, such as police reports.
- I) **Assessing Risk Level of Persons Who Use Violence and Coercive Control.**
- i) The following indicators are associated with an increased level of danger from batterers:
 - a) The batterer currently uses alcohol or drugs;
 - b) The batterer has access to weapons; or
 - c) The batterer has been trained in martial arts or boxing.
 - ii) The factors listed below must be considered when assessing potential lethality in families where there is domestic violence. The presence of any of these factors could increase the risk of homicide committed by the batterer, adult victim, or children and all interventions should be planned with this possibility in mind:
 - a) The batterer's access to adult victim;
 - b) Frequency and severity of abuse in current, concurrent or past relationships;
 - c) The presence of weapons in the home and the batterer's use or threat to use them;

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- d) Threats to kill themselves, the adult victim, children, or family members or pets;
- e) When the adult victim says the batterer has weapons in the home the Child Protection Specialist should confer with their supervisor and seek the assistance of law enforcement before proceeding;
- f) Hostage taking (e.g., not allowing the adult victim and children to leave);
- g) Current or previous incident involving strangulation or attempted strangulation of an adult, child or pet;
- h) Stalking;
- i) Past criminal record;
- j) Violence toward partner in public;
- k) Obsession with partner;
- l) Ignoring negative consequences of violence (e.g., out on bail, continuing violence, while on probation or under DCFS scrutiny);
- m) Depression or desperation;
- n) Psychosis, mental illness or brain damage;
- o) Certain medications;
- p) Suicidal ideation of the adult victim, children or abuser;
- q) Adult victim's use of physical force;
- r) Children's use of violence; and/or
- s) Past failures of intervention systems to respond appropriately.

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iii) Any batterer is potentially very dangerous and only a small number of batterers fall into the categories listed below. However, the following three batterer types create special cause for concern. **Heightened caution and alertness should be taken when meeting with alleged perpetrators who exhibit any of these behaviors.**

a) **The Obsessive Partner**

This type of batterer is the most likely to stalk, kill or injure the partner, even months or years after the partner has left or obtained an order of protection.

- 1) Presents with jealous behaviors;
- 2) Makes irrational accusations;
- 3) Cannot tolerate separation from the adult victim;
- 4) Monitors the adult victim's whereabouts through calls, questioning of children and others, check-up visits, etc.;
- 5) Makes threats to kill the adult victim if they leave;
or
- 6) Tells the adult victim, "If I can't have you, no one will."

b) **The Sadistic Partner**

- 1) Inflicts severe pain or torture to the adult victim such as burning, starving, strangulation, beating for an extended period of time, etc.;
- 2) Violence has a bizarre, depersonalized character;
- 3) Profound lack of consideration of the adult victim as a person (e.g., beating the partner just after he/she had an operation);
- 4) Assault without any warning or provocation;
- 5) Terrorizes the adult victim through continuous degradation;
- 6) Likely to retaliate severely against the adult victim even though appearing to agree with the adult victim;
- 7) Frequently has no criminal record; or
- 8) Usually employed, sometimes in a prestigious position.

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c) **The Hyper-Violent Batterer**

- 1) Takes offense easily;
- 2) Even mild attempts at limit-setting can trigger threats of violence;
- 3) Views many situations as challenges to courage and feels the need to continually prove themself;
- 4) Often has a long criminal record resulting from bar fights, brawling, assault and battery charges, etc.;
- 5) Generally aggressive;
- 6) Can be very dangerous to the adult victim, especially if the adult victim fights back; or
- 7) Often has very belligerent relationships with authority figures and may assault the Child Protection Specialist if feeling challenged.

iv) These categories are not mutually exclusive and coercive and violent persons may exhibit behaviors from multiple categories.

J) **Interviewing Collateral Contacts.** Collateral contacts must be made with individuals who can provide information concerning the safety and well being of the children, parental functioning, home environment, the relationship between the adults and between the adults and children (e.g., criminal justice personnel, child care providers, social service agencies, neighbors, school and medical personnel and extended family members with extensive/significant personal contact with the family). These are the people who interact most frequently with families and may hear or see signs and symptoms of domestic violence as well as child abuse or neglect. Additionally, they may receive disclosures directly from the family prior to DCFS involvement in an attempt to receive some form of support or assistance. Questions used to gather information from adult victims can be adapted for inquiries with collateral contacts.

g) **Clinical Services Support**

- 1) Child Protection Specialists should consult with a Clinical Domestic Violence Specialist in the Division of Clinical Services' Domestic Violence Intervention Program when an investigation involves one or more of the following dynamics during an incident of intimate partner violence. To request a consultation, the Child Protection Specialists shall send a **CFS 399-1, Clinical Service Referral Form** to DCFS.ClinicalRef@illinois.gov.
 - A) Use of an object or weapon;
 - B) Physical injury to a child;

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- C) Physical injury to an adult (non-offending caregiver);
 - D) Strangulation;
 - E) Forced restraint of an adult or child victim;
 - F) Willful deprivation of personal liberty of an adult (non-offending caregiver) or child;
 - G) When a child intervenes in a domestic violence incident;
 - H) When the family has a prior investigation involving domestic violence;
 - I) When the family or any case member has a documented or reported history chronic violence; or
 - J) Upon supervisory recommendation.
- 2) During consultation, Clinical Domestic Violence Specialists will provide:
- A) An overview of the overt and underlying dynamics of domestic violence in the case;
 - B) Identification of factors affecting child safety;
 - C) Recommendations for services and interventions for domestic violence and the child's exposure to violence in the home;
 - D) Assistance in identifying providers in the community that are appropriate for addressing the domestic violence service needs of the alleged perpetrator, non-offending caregiver and child; and
 - E) Educational materials pertinent to the domestic violence dynamics in the case.
- 3) **Consultation shall NOT be used to replace supervisory decision making or existing DCFS or private agencies' clinical processes.**
- 4) When protective custody is taken due even in part to an urgent and immediate risk of harm to children due to the presence or history of domestic violence, the Child Protection Specialist should disclose at the initial court hearing what they have learned, observed and documented about the presence, history and potential for on-going domestic violence for the family. Disclosure to the court should include the recommendations from the clinical consultation with the Department's Clinical Domestic Violence Specialist. The Child Protection Specialist should

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also disclose in court all service referrals made on behalf of the family and the response of the primary caregiver to each referral, and the recommendation provided by the Department.

- 5) For Intact Family cases, the Intact Family Worker and Supervisor shall explore the use of court-ordered service compliance for members of a family assessed as having a high level of risk for incidents of abuse or neglect and who demonstrate a lack of compliance with Department services.
- 6) **Domestic Violence Resources.** Listed below are additional domestic violence resources.
 - A) Illinois Domestic Violence Help Line: **1-877-TO-END-DV (1-877-863-6338)**
 - B) Chicago Metropolitan Battered Women's Network: **312-750-0730**
 - C) Illinois Coalition Against Domestic Violence: **217-789-2830**
 - D) National Teen Dating Violence Help Line: **866-331-9474**

h) **Staff Safety**

Learning to identify dangerous behavior and planning for self-protection is crucial when working with persons involved in domestic violence situations or other circumstances involving violence. The goal of identifying staff safety guidelines is so that child protection/welfare professionals are able to plan for safe contact with families that have experienced violence, and to further support safety plans for children that have been abused and/or neglected. Child Protection Specialists will need to use extreme caution when intervening on behalf of a family. Department involvement may increase the risk to both the family and Child Protection Specialist; a batterer may feel that the presence of an outsider (the Child Protection Specialist) threatens their level of control over others.

- 1) Child Protection Specialists should carefully consider the following guidelines if domestic violence is reported or suspected in an assigned investigation:
 - A) Consult with the Child Protection Supervisor about staff safety concerns;
 - B) When doing an assessment or interviews with the family, be aware of triggers of violence; and
 - C) Consider how the perpetrator's LEADS history could impact staff safety.

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- 2) Plan accordingly when working in high-risk situations. Take caution when meeting with the batterer alone.
 - A) When the alleged perpetrator has a violent criminal history, the Child Protection Specialist should involve local law enforcement to assist in conducting the interview; and
 - B) Assess the surroundings and create and maintain an exit strategy.
- 3) Certain situations can trigger violence in batterers. The Child Protection Specialist should be **ALERT** to the following circumstances:
 - A) Adult victim is preparing to leave (e.g., shelter, order of protection, separation or divorce);
 - B) Children are going to be removed;
 - C) Batterer has just been released from jail or is facing serious criminal charges and possible incarceration;
 - D) Allegations are made directly to the batterer regarding either domestic violence or child abuse and neglect; or
 - E) Batterer is requesting or demanding information regarding the family's location after a separation.
- 4) Child Protection Specialists should remember to:
 - A) Trust their instincts;
 - B) Stay calm;
 - C) Know that the batterer will try to test the Child Protection Specialist's limits; and
 - D) Do not to engage in confrontation.

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i) Documentation

- A) Information obtained from required domestic violence interviews, collateral contacts, as well as information relevant to safety assessment and protective actions must be documented in investigation interview notes and the initial and any subsequent **CFS 1441, Safety Determination Form** when evidence or circumstances suggest that a child's safety may be in jeopardy.
- B) When significant indicators of domestic violence exist, the Child Protection Specialist may offer a domestic violence brochure to the adult who is a possible victim of domestic violence, whether or not the level of risk to the child warrants any further involvement. The Child Protection Specialist should determine with the adult victim if it is safe for him/her to receive and retain this brochure. In some cases, the adult victim may state that it is not safe for him/her to keep the brochure. In such cases, the Child Protection Specialist can review the brochure with the adult victim and discuss the content, rather than leaving it with him/her. The brochure used for this purpose is the **CFS 1050-85, You and Your Children Have a Right to be Safe From Abuse: What You Need To Know About Domestic Violence And Child Welfare**. The **CFS 1050-85-S** is the Spanish translation version. The Child Protection Specialist shall consult with the Department's Clinical Domestic Violence Specialists for further guidance and clinical support concerning reports involving domestic violence.
- C) The Child Protection Specialist should help the children and adult victim develop an emergency plan for where to go (e.g., another room or a neighbor's house) if there is domestic violence, and how to access help.
- D) Child Protection Specialists should identify whether a Domestic Violence Shelter is a safe and viable option for the adult and child victims. Information on shelter vacancies can be readily accessed by calling the 24-hour Illinois Domestic Violence Helpline: **877-863-6338**.
- E) **If the caregiver is unable to demonstrate a capacity to protect the children in the home, and/or the presence of domestic violence creates safety and risk factors that compromise the children's safety, the children should be taken into protective custody.**
- F) All of these interactions should be documented in the electronic case record and in any hardcopies, especially all forms, with signatures, initials or acknowledgments of referrals or acceptance of services. Be sure to document when caregivers refuse or deny services. All communication between the worker and the family experiencing domestic violence or suspected domestic violence should be thoroughly documented. All documentation should be clear and concise. If referrals are made, document the agency, location, whether a contact person was identified and any scheduled appointments. Document all calls that are made with the family to community providers. Include the family members response to the referrals, note where family members are agreeable, reluctant or ambivalent. These all help to shape the rationale for investigative outcomes and determinations.

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APPENDIX K - INFANT SAFE SLEEP PRACTICES

a) Purpose

Improvements in the number and quality of death scene investigations, caregiver interviews and research data collection provide better information about infant deaths including those formerly referred to as “rollovers.” Unexplained infant deaths labeled SIDS about a decade ago are now referred to as Sudden Unexplained Infant Death Syndrome (SUIDS). SUIDS includes deaths attributed to Accidental Suffocation and Strangulation in Bed (ASSB), SIDS, and unknown causes. Many of these deaths can be directly attributed to unsafe sleeping conditions. The purpose of this protocol is to establish uniform procedures for investigating families when an SUIDS death is suspected.

b) Definitions

“AAP” means the American Academy of Pediatrics.

“Accidental Suffocation and Strangulation in Bed (ASSB),” a subset of SUID, is a leading category of injury-related infant deaths. Although evidence suggests that the rate of ASSB is increasing (Shapiro Mendoza, et al, 2006) ASSB deaths are potentially preventable.

“Asphyxia” means a lack of oxygen in the blood due to restricted respiration that, if severe enough and prolonged, causes death.

“Bed Sharing” means when another person, most often a parent or sibling, shares a sleep surface with an infant.

“Co-Sleeping” means a more general term than bed sharing. It can mean bed sharing or sleeping in close proximity to the infant (i.e., adult sleeping in bed with infant sleeping in safe crib in same room).

“Entrapment” means when an infant is stuck in a position in which they cannot get out. An example is when an infant is caught between an adult and the back of a couch/sofa or under the cushions, thereof.

“Intoxicated” refers to impaired capacity to attend to the needs of infant or child due to the influence of a mood-altering substance such as drugs or alcohol. Drugs may be prescription, over-the-counter or illegal.

“Loose Bedding” includes bed items such as cushions, pillows, comforters, blankets, quilts, bumper pads, stuffed animals, cords, positioners, wedges, etc.

“Overlay” means a type of unintentional suffocation that occurs when something covers an infant or someone rolls over onto the infant.

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“Prone” means lying on the stomach.

“Sleep-Related Deaths” include sudden infant death syndrome (SIDS), unintentional suffocation in bed and/or the cause listed as undetermined but the infant died during sleep.

“Soft Bedding” includes adult mattresses, comforters, cushions, pillows, quilts, sheepskins, etc.

“Sudden Infant Death Syndrome (SIDS)” means the sudden death of an infant less than one year of age that cannot be explained after a thorough investigation is conducted, including a complete autopsy, examination of the death scene, and review of the clinical history. (Center for Disease Control)

“Sudden Unexpected Infant Death Syndrome (SUID),” also known as sudden unexplained infant death, means the sudden and unexpected death of an infant in which the manner and cause of death are not immediately obvious prior to investigation. SUID can be caused by metabolic disorders, hypothermia or hyperthermia, neglect or homicide, poisoning, or accidental suffocation. Some SUIDs are attributed to SIDS and sometimes the cause is unexplained.

“Suffocation” means restriction of access to air or oxygen that can cause death.

“Supine” means lying on the back.

“Unintentional Suffocation” means a manner of death that occurs when loose materials or soft bedding block or cover the infant’s external airway.

“Wedging” means compression of the face or thorax against objects, as when an infant is trapped between a wall and mattress, caught in cushions of a sofa or chair, etc.

c) Background

SIDS remains the number one cause of post neonatal (age 1 month to 1 year) infant death. Approximately 90-95% of infants who die from SIDS have died by the age of 6 months with approximately 60% of deaths occurring in the 2 – 4 month age range. Approximately 60% of the deaths occur in males as opposed to 40% of deaths in females. Consistently higher rates are found in African American and Native American populations (2 to 3 times the national average). Among Hispanic subgroups, infant mortality rates ranged from 4.52 per 1000 live births for Central and South American mothers to 8.01 per 1000 live births to Puerto Rican mothers. (Mathews *et al*, 2011)

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The cause of SUIDS has not been determined, but there are common factors known to contribute to an increased risk of sudden unexplained infants deaths. These include:

- Infant sleeping in prone position;
- Use of soft or loose bedding (bumper pads, quilts, comforters, pillows, etc.);
- Unsafe sleeping environments (adult beds, couches, daybeds, waterbeds, etc.);
- Overheating due to high room temperature, excess clothing and blankets, and/or, head or face covered during sleep;
- Mother's age younger than 20 years;
- Mother smoking during pregnancy;
- Exposure to secondhand smoke;
- Mother receiving late or no prenatal care;
- Premature birth or low birth weight; and
- Mother's use of drugs or alcohol during pregnancy.

Large-scale epidemiologic studies by the American Academy of Pediatrics (AAP) have shown that high risk situations like maternal obesity, smoking, alcohol, drug use, overcrowding and the use of non-bed sharing surfaces like couches and chairs may increase the risk of accidental suffocation. Many of these contexts are particularly prevalent in urban poor families.

Although researchers do not yet know how to predict or prevent SIDS, accidental deaths due to suffocation, entrapment or overlay can be prevented by following safe sleep techniques.

Staff serving families with infants and young children must take the time to educate parents and caregivers about safe sleeping principles and dangers of co-sleeping. All direct service staff must ensure parents and caregivers are aware that an infant sleeps safest on his/her back in a **separate** sleep arrangement (e.g., crib, bassinet, portable play pen, etc.) that is free of objects that may pose an asphyxiation threat (pillows, large stuffed animals, thick blankets, cords, etc).

NOTE: If the family cannot afford safe/separate sleep items (bassinet, crib, playpen, etc.), DCFS will either provide one from current supply or purchase the article with **Norman Funds**.

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It is extremely important to discuss safe sleeping practices with the family even if a separate sleep area for the child is available in the home. A 2003 study of 102 accidental infant asphyxia deaths conducted by the Maryland Office of Chief Medical Examiner concluded that a crib was available in the home for 9 out of 10 asphyxiated co-sleeping deaths.

The following Safe Sleep practices from the National Institute of Child Health & Human Development (NICHD) must be shared and discussed with parents/caregivers:

- **Always place your baby in his or her separate sleep area on his or her back to sleep, for naps, and at night.** The back sleep position is the safest, and every sleep time counts.
- **Place your baby on a firm sleep surface, such as on a safety-approved crib mattress, covered by a fitted sheet.** Never place your baby to sleep on pillows, quilts, sheepskins, and other soft surfaces.
- **Keep soft objects, toys, and loose bedding out of your baby's sleep area.** Don't use pillows, blankets, quilts, sheepskins, and pillow-like crib bumpers in your baby's sleep area, and keep any other items away from your baby's face.
- **Do not allow smoking around your baby.** Don't smoke before or after the birth of your baby, and don't let others smoke around your baby.
- **Keep your baby's sleep area close to, but separate from, where you and others sleep.** Your baby should always sleep in a safe crib, bassinet, or portable play yard. Baby should never bed-share with anyone, and baby should not be put to sleep on non-bed surfaces like couches and chairs. Baby can sleep in the same room as caregiver, and it is alright to bring baby to bed for nursing, feeding, play and cuddle time. However, baby must be placed back into the crib, bassinet, or portable play yard for safe sleep.
- **Think about using a clean, dry pacifier when placing the infant down to sleep,** but don't force the baby to take it. (If you are breastfeeding your baby, wait until your child is one month old or is used to breastfeeding before using a pacifier.)
- **Do not let your baby overheat during sleep.** Baby needs the same number of layers as the adult caregiver plus one thin layer for sleep. Baby's head or face should never be covered during sleep.
- **Avoid products that claim to reduce the risk of SIDS** because most have not been tested for effectiveness or safety.

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- **Do not use home monitors to reduce the risk of SIDS.** If you have questions about using monitors for other conditions talk to your health care provider.
- **Reduce the chance that flat spots will develop on your baby's head:** provide "Tummy Time" when your baby is awake and someone is watching; change the direction that your baby lies in the crib from one week to the next; and avoid too much time in car seats, carriers, and bouncers.

d) Investigation and Intact Specialist Responsibilities

1) Investigations

Investigation Specialists are generally first responders to a family based upon a hotline report. The Specialist shall educate parents/caregivers about environmental threats to child safety and ensure safe sleeping arrangements as soon as possible after initiation. Specialists must ensure sleeping arrangements for **all household children** whether or not they are listed as primary victims. Safe sleep discussions and plans for the infant must occur if the mother and/or any household female is confirmed or suspected to be pregnant. The Specialist shall inspect for environmental threats and safe sleeping arrangements for each residence in which a family moves during an active investigation.

In family households (non-licensed facilities) where safe sleeping arrangements are insufficient or nonexistent, the Investigation Specialist must take immediate action to **specifically** address and resolve the safety threat **prior to leaving the family's home**. It is unsatisfactory to merely document the insufficient or nonexistent sleeping arrangements on the Home Safety Checklist, provide the "Safe Sleeping for Your Baby" brochure and tell the mother/caregiver not to sleep with the infant. **The Specialist shall call the supervisor or manager to discuss protective strategies up to and possibly including immediate provision of a crib, bassinet, portable play yard, etc.** The Specialist shall not leave the family's home until implementing the safe sleeping solution determined or recommended in consultation with the supervisor or manager (see Section 3 of these procedures, Safe Sleep Strategies).

2) Intact Family Services

If a case is opened to intact family services, the Intact Specialist shall periodically monitor sleeping arrangements for all involved children. Safe sleeping plans for the infant must be discussed if the mother and/or any household female is confirmed or suspected to be pregnant. Any changes in household composition or location shall require immediate assessment of sleeping arrangements and completion of the Home Safety Checklist. **The Specialist shall call the supervisor or manager to discuss protective strategies up to and including**

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immediate provision of a crib, bassinet, portable play yard, etc. The Specialist shall not leave the family's home until implementing the safe sleeping solution determined or recommended in consultation with the supervisor or manager (see Section 3 of these procedures, Safe Sleep Strategies).

Investigation and Intact Specialists must recognize increased threats to safe sleeping where one or both parents/caregivers appear intoxicated. In some cases, over-the-counter and prescription medication can increase inability to safely care for infants and young children. .

NOTE: If the household composition contains a child with developmental equivalency to an infant, the Specialist shall discuss safe sleeping arrangements with the parent or caregiver. The Specialist shall ask and document the doctors, therapists, etc. involved with the child and any discussions of safe sleeping they have had with the parents. In households where safe sleeping arrangements are insufficient or nonexistent, Specialists must take immediate action to **specifically** address and resolve the safety threat **prior to leaving the family's home**. For circumstances in which the developmentally delayed child is too large to be accommodated in a portable play yard, Norman Funds are appropriate for assistance.

3) **Safe Sleep Strategies**

The purpose of helping the parents/caregivers devise safe sleeping solutions is to underscore the importance of educating them of the dangers of co-sleeping and/or sleeping on surfaces not approved for infants. Many families may already have separate safe sleep surfaces for their infant and may only need to be reminded of the dangers of co-sleeping and/or allowing the baby to sleep on a surface not approved for infants. While it may not be possible to immediately provide a portable crib for the infant's family to use due to after hours/on-call assignment, distance from headquarters, etc, the Specialist and Supervisor must assess the family's current situation and determine a timeframe no later than three business days based upon availability from supplies issued for investigations and intact families. If Norman funds need to be accessed, the referral must be submitted for processing the following business day after contact with the family with the target of five business days for the family to have a safe sleeping surface for their infant. However, an interim solution must be developed and documented with the family prior to the Specialist leaving the home.

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The safe sleep solution determined in consultation with the Supervisor is a critical decision and must consider several factors:

- Immediate availability of an appropriate bed or crib;
- Prior involvement with the family during which infant safe sleep practices were discussed;
- History of parent/caregiver's substance misuse;
- Condition of the home. Homes that are cluttered, chaotic, in disarray or environmentally hazardous provide additional safety threats that might compromise temporary safe sleep solutions and require other critical decisions;
- Presence of small children and/or pets that might have access to the infant depending upon the strategy implemented.; and
- Parents/caregivers' understanding and willingness to cooperate with temporary solutions and ensure information is discussed with infant's substitute caretakers.

Temporary safe sleeping arrangements may vary depending upon capacity of parents/caregiver, available resources, safety decision, etc. Ultimately, the primary (or after hours) supervisor or manager will have to immediately approve the temporary safe sleeping arrangements or ensure delivery of a portable crib is expedited. In areas of limited cell phone reception (generally rural areas), the supervisor must review and approve the temporary sleep solution with the same expediency as approval for protective custodies.

The following may or may not be appropriate for every family and are *offered for guidance only*. *Possible* temporary safe sleep solutions might include, although are not limited to:

- An opened container-type item large enough and structurally sound enough for the infant. This might include an empty drawer removed from the dresser, a low-sided box with bottom and all sides secured, etc. Only light-weight (baby) blankets should be used, if parents/caregivers insist some sort of cushion is needed. However, no pillows, thick blankets, stuffed animals, thick clothing, other bedding etc, should be used;
- A safe firm low surface (floor) out of the path of foot traffic—not situated immediately to the side of parents/caregivers' bed where infant could be stepped upon and away from small children and animals;
- A pallet on the floor with light-weight blankets;
- An uncluttered area where nothing could fall into the sleep area on top of the infant restricting breathing;
- Parents/caregivers should be cautioned against sleeping with the infant on a couch, easy chair, etc, as these are not an acceptable temporary solution.

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Any decision to take temporary protective custody must include imminent threats to the infant's safety and the totality of the family's situation (allegations, prior history, dynamics, etc). The absence of a safe separate infant sleep surface **in and of itself** is not sufficient for protective custody but requires immediate documented protective action.

e) **Death Investigations Due to Unsafe Sleeping Arrangements**

Research findings conclude unsafe sleep arrangements are a highly significant risk factor associated with SUID. Good practice requires a thorough and competent death scene investigation and scene re-creation. The scene re-creation will demonstrate the presence of unsafe bedding, sleeping conditions, and/or positioning of the infant that resulted in unintentional suffocation or presented an environmental challenge that may have contributed to the death.

Procedures 300 requires a scene investigation for many allegations and for most death investigations, law enforcement is immediately involved. However, there are situations in which the law enforcement investigation may be suspended if their assessment is accidental lay over. If law enforcement is involved, the Investigation Specialist should ask if the scene investigation has occurred and have the results shared with DCP. If the scene investigation has not taken place, the Specialist must immediately ask if doing so compromises the law enforcement investigation. Once cleared to proceed, or if informed law enforcement indicates they will not do so, the Investigation Specialist must complete the scene investigation immediately. All discussions with law enforcement about the scene investigation and/or any aspects of the investigation must be immediately and carefully documented.

The Specialist shall obtain a detailed description of events surrounding the infant's death. A scene investigation shall include, but is not limited to:

- Environmental circumstances surrounding the incident (i.e., objects, times, and distances involved);
- Events leading to the incident, including a 24-48 hour timeline of sequence of events leading to the incident;
- Persons in the environment at the time of the incident;
- Extended family members or other collaterals that have had contact with the infant and may have witnessed the incident;
- General safety conditions of the home, including temperature of the room in which the death occurred (extremely hot or cold);
- How the incident occurred (mock demonstration by the alleged perpetrator and other witnesses). Use a pro-doll for reenactment purposes;

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- The temperament of the child and alleged perpetrator (was the infant fussy, feeding normally, etc.) including level of stress in the home prior to the incident;
- Use of alcohol or drugs (prescription, over the counter, etc.) by alleged perpetrator prior to the incident;
- If the infant was ill or on any medication, including: where medication is kept, type, dosage schedule, when last administered and by whom, prescribing physician, etc.;
- If the infant experienced any head injury in the hours before the death;
- Position in which infant was put down;
- Last time infant was fed, what was given and by whom;
- Where child was found and by whom, including infant's position, type of surface (crib, couch, waterbed, stuffed toys, soft bedding, pillows, etc);
- List and interview any adults or other children who shared the sleep surface with the infant;
- Identify who was the primary caregiver (providing more than 50% of the care);
- Availability of separate sleeping area for the infant during time of incident;
- Alleged perpetrator's awareness of safe sleeping practices prior to the incident;
- Identify last person to see infant alive;
- Other activities as directed by the supervisor or indicated by the circumstances of the investigation;
- If the death occurred in an environment other than the primary residence, a scene investigation must occur in that place as well; and
- Interview all caregivers (relatives, babysitters, etc.) regarding conversations with the parents concerning safe sleeping.

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f) Photographic Documentation

Photographic documentation of the scene creates a historical record and provides detailed corroborating evidence that constructs a system of redundancy in the event of questions raised regarding the report, witness statements, etc. The Specialist shall ensure that accurate scene photographs are taken and available to re-create and assess the scene.

g) Resource

SIDS of Illinois is a non-profit organization that can serve as an educational and supportive resource to families who have experienced the loss of an infant due to SIDS/SUID. Investigations and Intact Specialists can call 1 800-432-SIDS (7437) to refer families to SIDS of Illinois.

Refer to Procedures 300 and Appendix B for additional guidelines on conducting death investigations.

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APPENDIX L – FACTITIOUS DISORDER BY PROXY (MEDICAL CHILD ABUSE)

a) Purpose

The purpose of these procedures is to provide information about Factitious Disorder by Proxy (FDP), also referred to as Munchausen by Proxy (MBP) syndrome and more recently, Medical Child Abuse, and to provide guidelines for investigating reports of abuse and neglect when the child's parent or caregiver is suspected of having this disorder. FDP is a complex form of child abuse requiring a carefully coordinated multidisciplinary approach.

b) Definitions

Factitious Disorder by Proxy

- “Factitious” means not real, genuine, or natural. Factitious disorders are therefore characterized by physical or psychological symptoms that are intentionally produced or feigned.
- “Proxy” means acting through a substitute or via another person.

The following definitions and examples were adapted from *Munchausen by Proxy (MBP) Maltreatment Manifesting as Child Sexual Abuse* by Louisa J. Lasher, M.A. and Marc D. Feldman, M.D.

“Feign” means that an intentionally false medical report of a child is made to professionals by the child's parent. For example, a sleeping infant is reported to 911 to have been resuscitated by his or her parent after the parent allegedly found the infant not breathing and turning blue.

“Exaggerate” means that a child's medical condition is overstated by his or her parent. For example, a child has a low-grade fever (100.5°) that has lasted several days, and the child's parent reports on multiple occasions to the pediatrician that the child's temperature ranges between 103° and 105°.

“Simulate” means that the child's parent manufactures evidence of an illness and conceals his or her involvement in the deception. For example, the mother of an infant that is not ill places a substance that appears to be vomit next to the child and reports to the child's father that the child has been throwing up.

“Aggravate” means that a child's pre-existing medical or psychological problem is worsened by his or her parent. For example, a child has juvenile diabetes mellitus that requires a daily injection of insulin administered by the parent. And the parent deliberately causes the child's blood sugar level to rise by giving the child an incorrect dosage of insulin.

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“Induce” means that the parent deliberately causes the child’s medical problem. For example, the parent calls for help after he or she gives the child a substance to cause vomiting.

“Symptom collusion” means a defense mechanism used by the victim to protect his or her family from outside forces. For example, an older child may consciously or unconsciously keep secrets about actual symptoms or illness to protect himself/herself or the family; and/or to preserve secondary benefits gained from the results of the symptoms or illness.

c) **Characteristics of FDP**

Factitious Disorder by Proxy (FDP) is a mental illness in which a person acts as if an individual he or she is caring for has a physical or mental illness when the person is either not actually ill or not as ill as reported. People suspected of FDP assume the role of a sick person indirectly by producing symptoms or lying about the health of a person under their care, usually a child under 6 years of age. This is not done to achieve a concrete benefit such as financial gain. People with FDP have an inner need for the child to be seen as ill or injured in order to garner sympathy and special attention given to people who are truly ill and/or the dedicated parents caring for them. FDP is a form a child abuse that occurs in all-racial and socio-economic groups.

Note: Factitious disorders are considered mental illnesses because they are associated with severe emotional difficulties. *Diagnostic and Statistical Manual of Mental Disorders*, Forth Edition (DSM-IV)

The following characteristics are common in persons with FDP.

- The perpetrator often is a parent, usually the mother;
- The perpetrator might be a health care professional or has had some type of medical training;
- If married, the spousal relationship is usually shallow;
- The perpetrator is very friendly and cooperative with health care providers;
- The perpetrator appears quite concerned about the child, but may have a hostile, difficult and demanding personality outside a medical setting;
- The perpetrator may have a tendency toward self-dramatization or incessant need for attention.

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d) Effects of FDP

This disorder can lead to short-term and long-term complications that include continued abuse, life threatening events, multiple hospitalizations, and the death of the child victim.

Warning signs of FDP include the following:

- The child has a history of many hospitalizations, often with a strange set of symptoms;
- Worsening of the child's symptoms generally is reported by the mother and is not witnessed by hospital staff;
- Representation of the child's condition and symptoms that do not agree with the results of the diagnostic tests (e.g., induced symptoms vomiting, diarrhea, fevers, infections, bleeding, central nervous system depression, and fever);
- There might be more than one unusual illness or death of children in the family (e.g., miscalculates the smothering of the child or gives the child too much medication);
- Blood samples found in the child's urine or stool specimens might not match the blood of the child;
- There might be signs of chemicals in the child's blood, stool, or urine (e.g., potassium, acetaminophen, aspirin, insulin, prescription medication, diuretics, illicit drugs, arsenic, noxious substance, and other toxic substances);
- The child's reported condition improves in the hospital, but symptoms recur when the child returns home.

e) Investigation Process

Factitious Disorder by Proxy/Munchausen syndrome by proxy has not been assigned an allegation number as part of the Department's allegation system. When FDP is reported by a medical professional and the information provided does not meet the criteria for an existing allegation, **the SCR will take the report and assign Allegation #10/60, Substantial Risk of Physical Injury.**

In cases where FDP has been confirmed by medical personnel (i.e., physician, psychiatrist, psychologist) the first concern is to ensure the safety and protection of the victim and potential victims. Managing a case involving FDP often requires a team that includes social workers, foster care, law enforcement, and health care workers.

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Most incidents of suspected FDP are based solely on circumstantial evidence. The combination of the unique type of evidence gathering and criminal properties of the disorder require a multidisciplinary approach and cooperation between agencies to avoid error or loss of potential evidence. Required documentation for investigations where FDP is suspected includes the following:

- Interview all persons that suspect the alleged perpetrator of FDP. Document on a SACWIS Contact Note each person's qualifications, the basis of the facts leading to their suspicion of FDP, and the impact on the alleged child victim's health;
- Obtain the medical histories for the alleged child victim and his or her siblings; names of all the treating physicians; hospital admissions and dates; presenting symptoms; medical procedures performed; and medications given to the child since birth. Attempts should be made to obtain this information from the child's parents;
- Names of all living and deceased siblings of the alleged child victim. Document the reported cause of death for all deceased siblings. If any of the deaths were attributed to SUIDS or undetermined, identify the city, county, state and dates of the deaths;
- Complete a non-rushed medical records review of all the children in the home, and case conference with as many previous treating physicians as possible. This should be completed in conjunction with the activities of the multidisciplinary team if one has been formed or through a consulting physician coordinated by a Department nurse. Care should be taken to document the following questions related to symptoms. The information will often strongly suggest that the lack of clinical-sense of the case is not resulting from some medical problem in the child;
 - i) If the symptoms are suspected of being induced, how were they induced?
 - ii) If the symptoms were chemically induced, how long would it take for the symptoms to appear after the administration of the chemical, and how long would these last?
 - iii) What was the circumstance of the onset of the symptoms?
 - iv) Who was present prior to the onset of the symptoms?
 - v) Do the medical records of siblings contain evidence of false pediatric reporting?
- Assess the alleged perpetrator's medical and physiological histories;
- Identify all persons that have access to the child or care for the child (e.g., teachers, babysitters, relatives, co-workers, previous spouses, paramours, clergy, etc);

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- Identify all prescription and non-prescription medication in the child's home. Also document the name of the prescribing physician and dosage instructions. This should be completed for each location where the child has been if it is believed that the child was medicated at another location;
- Make a referral to law enforcement and the State's Attorney;
- Complete a 24 to 72 hour timeline of events prior to the most recent hospitalization of the child victim. The timeline must identify who was in the household; activities and family behaviors; persons who cared for the child and their mood; the child's routine (i.e., eating, sleeping and awake patterns); and the child's fussiness or crying. This will assist the Investigation Specialist in identifying the stress or risk factors present prior to the most recent incident;
- Complete a scene investigation that documents the environmental circumstances surrounding the incident; location of objects, implements, medications, chemicals near the child's location; assessment of any children at the location that would be able to access the afore-mentioned items; areas occupied by the child and items contained in that space; general safety conditions of the child's home; and other activities directed by the Investigation Supervisor or case circumstances.

f) **Required Contacts and Activities**

In addition to the established investigative requirements for the allegation or allegations identified in the SACWIS Intake, the Investigation Specialist must do the following upon notification that FDP is suspected:

- Immediately contact with the Department's Medical Director to discuss the investigation, information to date and planned activities. It may be necessary to have frequent communication with the Medical Director as information becomes available. Consultation must also occur prior to entering the final finding;
- Contact Department nursing staff and schedule a meeting to discuss the case. Use the assigned Department nurse to interpret medical terminology and medical documents. The nurse must also be included in multidisciplinary meetings. All contacts with the nurse must be documented on a **SACWIS Contact Note**;
- Notify law enforcement within 24 hours and obtain copies of applicable police reports involving persons in the child's home. See **Procedures 300.50** if law enforcement will take the lead in the investigation;
- Schedule a multidisciplinary team meeting with involved medical staffs, law enforcement and other team members to address immediate concerns for the child victim's safety, evaluation of case information, and the methods for the development of the necessary evidence to confirm FDP;

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NOTE: The existence of one or more physicians who may actively support the suspected parent or who hold a unique medical theory about the child's condition that does not coincide with other physicians treating the family should not be reason to suspend investigative activities or determine there is no merit to suspicions of FDP. In many situations, parents who practice this form of abuse are effective at securing allies or finding doctors vulnerable to their deceptions or willing to entertain improbable theories rather than accept the possibility of intentional deception. *Thus, professional opinions of child abuse experts on hospitals' Child Protection Teams must be given more credence than primary care physicians.*

- Complete in-person and individual interviews with all the children in the alleged perpetrator's household;
- Complete in-person and individual interviews with all adults in the child victim's home. If the alleged perpetrator is not a member of the child's household, complete in-person and individual interviews with all adults and children in the perpetrator's household.

g) **Protection of the Child Victim and Siblings**

When FDP is suspected, assessing the safety of the child victim requires coordination with the multidisciplinary team. If the alleged child victim is hospitalized, an assessment needs to be made concerning whether to limit, deny or monitor the alleged perpetrator's contact with the child. Persons monitoring parents' visits with the child must actively listen to conversations with the child and must never leave the child unsupervised with the parent. Observation notes should become part of the child's hospital record. The Investigation Specialist must also obtain a copy of the observation notes for the investigative file. If available and deemed appropriate by the hospital, covert video surveillance of persons visiting the child should be conducted.

Note: Evidence that is needed to demonstrate the alleged perpetrator's hand, aside from careful laboratory documentation, can often be garnered from a "separation test" that demonstrates that the child is free of disease outside the care of the perpetrator. Although covert video surveillance of persons suspected of FDP is highly effective in exposing fraud, it may also be considered grounds for a lawsuit on grounds of entrapment.

Prior to initiating an out-of-home safety plan, a thorough assessment of the relatives must be completed due to the fact that the parent often convinces the relatives of the legitimacy of the child's symptoms, and that the parent is devoted and caring. The safety plan must have a well-constructed monitoring component. The Investigation Supervisor is responsible for ensuring that staff complies with the monitoring requirements of the safety plan.

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h) Supervisor Management of FDP Investigations

Reports involving FDP should be assigned to Investigation Advanced Specialists or to Investigation Specialists with the experience and skills necessary for such complex investigations. When the suspicion of FDP is developed during the course of an investigation, the Investigation Supervisor and Manager must assess the merit of transferring the case to an Investigation Advanced Specialist.

Upon notification that a case involves FDP, the Investigation Supervisor will immediately notify the Investigation Manager. The Investigation Supervisor must also conduct formal in-person supervision sessions with the assigned Investigation Specialist on a weekly basis, or more frequently if directed by the Investigation Manager. Supervision sessions must include discussions concerning investigation-specific information; safety plan monitoring; multidisciplinary team meetings; coordination and comparison of investigation information; and other information as determined by the Investigation Supervisor.

The assigned Investigation Specialist must refer the case to the State's Attorney. The screening packet provided to the State's Attorney must include available medical records for the alleged victim and his or her siblings, and copies of all required investigative activities and contacts. When action is not taken by the State's Attorney, or temporary custody is not granted, the Investigation Specialist must offer the family intact family services.

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