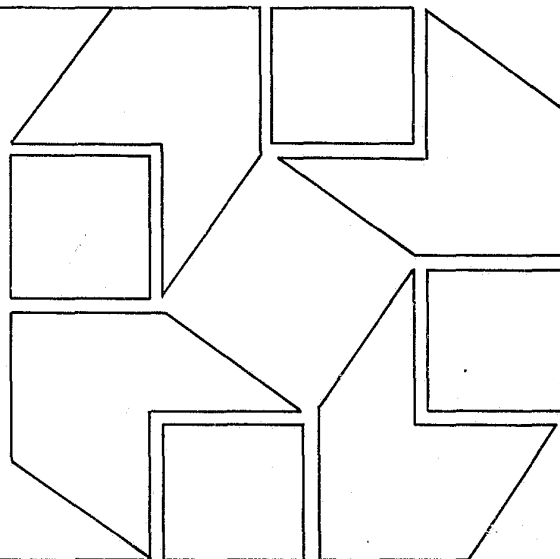




# COLORADO'S GUIDE FOR INVESTIGATING ABUSE AND NEGLECT IN OUT-OF-HOME CHILD CARE SETTINGS

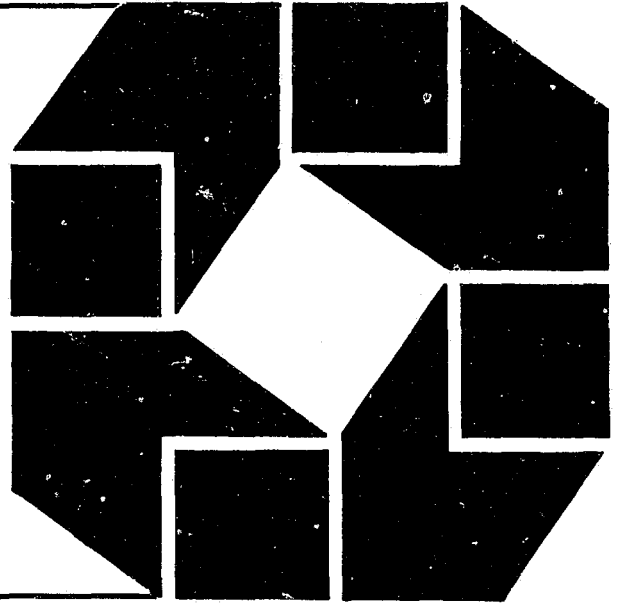
*January, 1987*



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# COLORADO'S GUIDE FOR INVESTIGATING ABUSE AND NEGLECT IN OUT-OF-HOME CHILD CARE SETTINGS

January, 1987



Published by the Colorado Department of Social Services with funding from the National Center for Child Abuse and Neglect Administration for Children, Youth and Families, United States Department of Health and Human Services.

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## ABOUT THIS GUIDE

The prevention and treatment of child abuse and neglect in out-of-home child care settings has been a departmental priority for several years.

The State Institutional Child Abuse and Neglect Advisory Committee has been reviewing cases of abuse and neglect in residential care since 1983. Through the review of these cases, that committee has identified the problems system wide which needed to be addressed. Among those areas identified was the need for training for those investigating the cases. Additionally, the need for statewide procedures and practice guidelines has been very apparent.

Three training sessions for county staff involving approximately 120 participants have been conducted by Cornell University's Residential Care Project and funded by state child abuse grants from the National Center on Child Abuse and Neglect, U.S. Department of Health and Human Services. In October, 1985 the Colorado Department of Social Services was awarded a grant to fund the "Interagency Project for Prevention of Abuses in Out-of-Home Child Care Settings." The development of the procedures is one of several components of that project.

The development of these procedures began with a working conference involving approximately 60 professionals including representatives of county social services, law enforcement, foster homes, group homes, residential child care facilities, institutions, day care centers, head start, county attorney, Attorney General, State social services, mental health, education, and the State Institutional Child Abuse and Neglect Advisory Committee. Participants at this conference identified the issues and developed guidelines for procedures. Five multidisciplinary task forces completed the development of the project.

Procedures and practice presented herein represent much time and effort as well as knowledge and expertise of many contributors. The Department is more than appreciative of the efforts of each and everyone.

This procedural handbook should prove to be useful to all agencies and individuals involved in an investigation as well as to the providers of out-of-home care.

Janet K. Motz, Project Director  
Interagency Project for Prevention of Abuses  
in Out-of-Home Child Care Settings  
Colorado Department of Social Services

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COLORADO DEPARTMENT OF SOCIAL SERVICES  
CHILD WELFARE SERVICES

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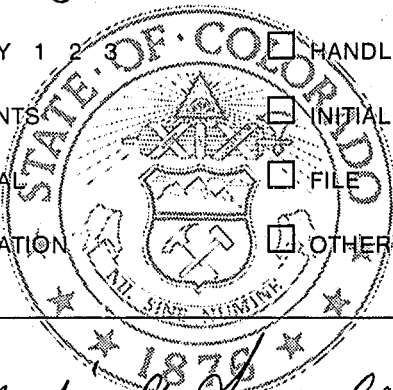
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MEMO

DATE 3/29

TO <i>Ms. Alice Liu</i>	
FROM <i>Rose Randle</i>	
DEPARTMENT <i>Child Protection Grants Unit</i>	
LOCATION <i>Denver, CO 80203</i>	TEL., OR EXT.

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# I. INTRODUCTION

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The problem of abuse in out-of-home child care settings has been a focus of national attention for the past decade. The initial focus was children in residential care settings. Only in recent years has sexual abuse of a child in a partial-care setting gained the attention of the media.

There have been and continue to be many barriers to the development of prevention programs; statutes; procedures for investigation and remedial action; and an effective reporting system to protect the child. There are polarized viewpoints on the nature and magnitude of the problem. There are those who believe that placement of a child in an institutional setting is in and of itself abusive; and, a majority who have concluded that the child is better cared for following placement than would otherwise be the case.

Overburdened child protective service systems are reluctant to include investigation of abuse in an out-of-home care setting within their scope of services. These cases are very complex and time consuming. There are no legal remedies other than criminal, and very few staff have the specialized training and knowledge required to handle these investigations.

The public, the professionals, as well as the community at large often fail to recognize adolescent abuse. This occurs particularly when these adolescents require placement in residential care because of delinquency or status offenses. They are the "throw-away children", and there is a sparsity of empathy for them. Abuse of adolescents in a residential care setting is regarded as deserved or "self defense". The understanding and sympathy is given to the perpetrator. Advocates for these adolescents are few. Their parents/guardians are often unwilling, unable or lack the knowledge to tackle the system on behalf of the children. Conflict of interest runs rampant in these situations. Bias is rarely in favor of the children. The system in many cases which has placed the children in residential care is also investigating the allegations of abuse.

Federal statutes and regulations require a separate, disinterested agency approach to investigations of abuse and neglect in an out-of-home care setting. Model standards propose the creation of a state agency which would be charged solely with investigations of abuse in out-of-home care settings.

Experience, research and demonstration projects have provided compelling reason to believe that many professionals charged with these investigations more often than not have a conflict of interest ranging from the obvious to the discreet. In some situations the same person who licenses, and/or places and supervises children in foster care is responsible for investigating allegations of abuse in those settings.

A more discreet conflict of interest situation might occur when the police are charged with investigating an allegation of abuse in a juvenile facility. The police have arrested these juveniles and often transport them to the facility. In many instances these law enforcement officers have consciously or unconsciously discounted the abuse allegation prior to any investigation.

Because of limited resources, Colorado has been utilizing existing resources and has made attempts to maintain a separate disinterested approach. Some of the small and middle-sized counties arrange to have another county investigate allegations of abuse in county foster and group homes. Some of the larger counties' intake staff have no contact with foster homes and maintain a disinterested approach in such an investigation.

Clearly persons who license, place or supervise foster homes SHOULD NEVER be responsible for any part of an investigation of abuse or neglect in those homes. There have been many instances in which the safety of a child has been jeopardized when an abuse allegation was minimized by workers who had an interest in the foster/group home or who had no other placement for the child.

As indicated in the procedures, county departments should make every effort to see that these investigations are carried out by a disinterested party to ensure better protection of children. County departments are most vulnerable to successful law suits when maltreatment occurs within an out-of-home care setting.



We must be aware that protection of children in out-of-home care settings is a separate issue from protecting children within the family context:

- ...“Parental discretion in childrearing is inherently broader than state discretion...
- ...“State responsibilities for meeting standards and tests of adequacy concerning childrearing practices exceed those applied to parents...
- ...“Mitigating circumstances, intent and severity are not relevant criteria for determining child abuse or neglect in a residential placement setting. Determination rests solely upon the occurrence of an incident and the foreseeability of its outcome...
- ...“The scope of culpability is greater in residential placements than in the family context...
- ...“Residential placement facilities are not commonly subject to public scrutiny or independent assessments of maltreatment complaints.”<sup>1</sup>

It is a given that abuse does occur in out-of-home care settings and sometimes that abuse has resulted in permanent damage or death. We must dispel any notion that the safety of a child is ensured when placed in a residential care setting and stop minimizing or discounting allegations in these settings. These cases should be a HIGH PRIORITY for investigation. In many cases the child is in a closed setting and has no one to protect him/her. Numbers of children may be at risk of abuse/neglect in that setting. Abuse perpetrated by a care giver is more damaging than abuse suffered at the hand of the parent(s).

The county is totally responsible for protecting the child in its custody for placement. These investigations should not only be high priority in terms of immediacy, but also for quality and should be done by skilled and specially trained workers. These cases should be critically reviewed by administrative or supervisory personnel and child protection teams as would a serious case of familial abuse. When abuse and or neglect are ruled out because of an inadequate and/or biased investigation, the child is further jeopardized. In addition, the county is very vulnerable to a successful lawsuit should there be future incidents.

It is time that everyone really consider the gravity of situations in which children are removed from their natural homes because of an environment considered to be injurious and then placed in a setting in which they are again, and sometimes more seriously, physically, sexually, or emotionally abused, and/or neglected. The harm done by the system in these cases is severe and lasting.

It is with this consideration that the following procedures have been developed for the use of all involved in these investigations.

---

<sup>1</sup>George Thomas, Ph.D., President, Regional Institute of Social Welfare Research, Inc.

## II. IDENTIFICATION AND REPORTING

---

The purpose of this section is to provide you with guidelines regarding the identification and reporting of abuse by staff in an out-of-home child care setting. Specifically: **who** should report; **what** should be reported and **when, how and to whom** a report should be made.

### A. Who should report known or suspected child abuse and/or neglect?

Persons required to report child/ren abuse and neglect are identified in 19-10-104 (1), (2) (a-n) (3), **C.R.S.**, 1986:

- (1) Any person specified in subsection (2) of this section who has reasonable cause to know or suspect that a child has been subjected to abuse or neglect or who has observed the child being subjected to circumstances or conditions which would reasonably result in abuse or neglect shall immediately report or cause a report to be made of such fact to the county department or local law enforcement agency.
- (2) Persons required to report such abuse or neglect or circumstances or conditions shall include any:
  - a. Physician or surgeon, including a physician in training;
  - b. Child health associate;
  - c. Medical examiner or coroner;
  - d. Dentist;
  - e. Osteopath;
  - f. Optometrist;
  - g. Chiropractor;
  - h. Chiropodist or podiatrist;
  - i. Registered nurse or licensed practical nurse;
  - j. Hospital personnel engaged in the admission, care, treatment of patients;
  - k. Christian science practitioner;
  - l. School official or employee;
  - m. Social worker or worker in a family care home or child care center as defined in section 26-6-102, C.R.S.
  - n. Mental health professional.
- (3) In addition to those persons specifically required by this section to report known or suspected child abuse or neglect and circumstances or conditions which might reasonably result in abuse or neglect, any other person may report known or suspected child abuse or neglect and circumstances or conditions which might reasonably result in child abuse or neglect to the local law enforcement agency or the county department.

Clearly from the above reference, all persons responsible for and/or involved in the care and supervision of a child/ren in an out-of-home care setting are required to report abuse and/or neglect.

Additionally, 19-10-104 continues:

- (4) Any person who willfully violates the provisions of subsection (1) of this section:
  - a. Commits a class 3 misdemeanor and shall be punished as provided in section 18-1-106, C.R.S.;
  - b. Shall be liable for damages proximately caused thereby.

### B. What should be reported to the county department of social services or law enforcement agency?

The following types of known or suspected abuse or neglect should be reported:

1. Physical maltreatment: any injury which is the result of the actions or omissions of a caretaker.
2. Sexual maltreatment: any sexual contact or sexually exploitative behavior involving a caretaker.
3. Failure to provide: with food, clothing, shelter or medical care necessary for a child/ren's growth and development including the timely provision of medical care.
4. Failure to supervise: to provide monitoring, guidance, structure, restraint or discipline necessary to protect a child/ren from harm.
5. Emotional maltreatment: acts or omissions of an adult caregiver which could be expected to retard or damage a child/ren's emotional development or aggravate an existing impairment.
6. Harmful restraint and/or control: inappropriate use of restraint, isolation or medication which could harm or endanger a child.

However, if there is any reason to question whether or not an incident, circumstance or concern should be reported, **IT CATEGORICALLY SHOULD**

For more detailed information see: Appendix A, **Indicators of Child Abuse and Neglect in Institutions**, Ohio Manual, section covering "Protection of Children in Institutional Care: A Guide for Public Health Service Workers".

**C. When should a report be made?**

IMMEDIATELY. It is recommended that an official report to the county department of social services or a law enforcement agency be made by the required person/s within one hour from the time it is known or suspected that abuse/neglect has occurred.

**D. How and to whom should a report be made?**

An official report of known or suspected abuse should be called in over the phone within one hour to the county department of social services or law enforcement agency.

It should be followed up immediately with a written report pursuant to section 19-10-108 of the **C.R.S., 1986**. See Appendix B, **Alleged/Suspected Child Abuse/Neglect Report** for a sample of a written form developed and utilized by Colorado State Hospital personnel.

The above statute specifies the reporting procedures and to whom a report should be made; see Appendix C, **19-10-108, C.R.S., 1986**, for full section verbage.

In those agencies, schools and institutions which have developed and implemented an internal reporting policy, such policy must be consistent with Appendix C, **19-10-108, C.R.S., 1986**.

A policy which requires a staff member to report upward through the chain of command instead of directly to the county department of social services or law enforcement agency does not waive that staff member's statutory obligation to report under Appendix C, **19-10-108, C.R.S., 1986**.

An "official report" is made when it is received by the county department of social services or law enforcement agency. A reporting policy must also include criterion that an "official report" be made immediately which means within one hour.

All staff should receive a copy of agency policy, should be trained in its use and receive on-going training as a requirement of the position.

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<sup>2</sup> **A Study to Define and Assess Severity of Institutional Abuse/Neglect**, pages 286-287, by M. Rabb and N. Rindfleisch.

### III. INVESTIGATION PROCESS

---

The investigation of abuse in an out-of-home child care setting is a two-stage process.

**A. Stage I: The investigator must determine:**

1. The immediate safety of the child/ren.
2. Whether the incident occurred independent of extenuating circumstances.
3. Whether the perpetrator(s) is culpable and in what manner.

Stage I of the investigation is the responsibility of the county department of social services.

**B. Stage II: The investigator must determine:**

1. Whether the administrative authority is culpable.
2. In what manner.
3. If the problem is administratively redressable.

Stage II is the responsibility of the licensing or certifying authority; see Appendix D, **Licensing and Certifying Authority**.

**C. Overlap of responsibilities:**

There may be an overlap in the Stage I and II investigation. Stage I investigators may make a determination that the administrative authority:

1. Is culpable.
2. That the problem is administratively redressable.
3. And, make recommendations to correct that problem.

For example, county staff might determine in the course of an investigation that the child was injured during physical restraint. Even though physical restraint is by policy utilized at the facility, the child care staff responsible for the incident had not been trained.

The worker should identify and address that issue as a part of the Stage I investigation. The worker should also address any concerns regarding child care practices. Stage II investigators may further investigate to determine if there are additional problems at the facility.

## IV. STAGE I INVESTIGATION

---

- A. Each county department of social services department should develop its own protocol for investigation of abuse in out-of-home child care settings to cover the following:
1. Who will do the investigations?
    - a. The county director or designated administrator or supervisors should identify one or more staff who will be assigned to investigate reports of abuse in out-of-home child care settings.

Because these investigations differ from the investigations conducted in a family setting, the agency should assign highly skilled staff who have been provided with specialized training in the investigation of abuse and neglect in an out-of-home child care setting.<sup>3</sup> See Appendix E, **Proceeding with the Investigation**, Ohio Manual, section covering "Protection of Children in Institutional Care: A Guide for Public Health Service Workers".
    - b. Federal regulations require that the investigation of abuse in an out-of-home child care setting be conducted by an agency other than the agency with licensing and oversight responsibilities, or which otherwise has a relationship with the child care setting, Federal Regulations 45 CFR 1340.3-3 (d)(3).

These regulations are based on the premise that there could be a conflict of interest and that investigators may be biased. This could jeopardize the safety of the child/ren. County departments should consider conflict of interest when reports are received.

Clearly county staff responsible for licensure evaluation or oversight of day care homes, foster homes, group homes or persons who are responsible for children in these settings SHOULD NOT conduct any part of the Stage I investigation. Larger county departments whose intake units are separate are sometimes better able to conduct objective investigations.
    - c. The entire staff in smaller counties is often involved in some respect with day care, foster care and group homes. Some of these departments currently have agreements wherein investigations of county foster homes and group homes are investigated by staff from a contiguous county.

Some large counties likewise arrange for staff from contiguous county departments to conduct investigations in conflict of interest situations. It is highly desirable for all counties to make arrangements for these investigations to be conducted by another county department. County departments MUST ensure a separate, disinterested investigation.
  2. Who is notified internally?

Each county department should determine who within the agency is to be notified when a report of abuse in an out-of-home child care setting is made. Generally, some level of supervisory or administrative personnel within the department should be advised and consulted when these reports are received for a number of reasons:

    - a. To determine appropriate case assignment.
    - b. To be prepared to provide back-up in the event of multiple abuse.
    - c. To be prepared in the event of media involvement.
    - d. To be prepared for the liability issues involved.
  3. How will medical exams be completed?

A child/ren who is suspected to be a victim(s) of abuse and has an injury or other condition, i.e., underweight, sexual abuse, head trauma, internal injuries, etc., should be examined by a physician, or minimally by a nurse who has expertise with non-accidental trauma. The parent(s) of the child/ren in day care will be responsible for obtaining a medical examination.
- B. Each county department of social services department should develop an agreement with the local law enforcement agencies regarding investigations of abuse and neglect in out-of-home care settings.

<sup>3</sup> The Colorado Department of Social Services has provided three training sessions for 120 county staff which were held in July 1985, January 1986, and September 1986. The sessions were conducted by trainers from Cornell University's Family Life Development Center, Residential Care Project.

1. When will law enforcement get involved?
2. Will there be a joint investigation or will it be carried out independently. There must be a clear role differentiation between law enforcement officers and social service workers.

A LAW ENFORCEMENT INVESTIGATION REGARDING THE CRIMINAL ASPECT OF THE CASE DOES NOT RELIEVE THE DEPARTMENT OF ITS RESPONSIBILITY TO ASSESS THE SAFETY OF THE CHILD/REN IN THE OUT-OF-HOME CARE SETTINGS IN WHICH THERE HAS BEEN AN ALLEGATION.

Advance planning with law enforcement agencies regarding abuse reports in out-of-home care settings is very important so that a procedure is known to both agencies in the event of a report.

C. The investigation.

1. The investigating worker shall obtain as much of the following information as possible from the reporting party.
  - a. Name, address and present location of the alleged child/ren victim(s), i.e., is the child still in the facility, at the nurses' station, etc.?
  - b. Child/ren's age and the nature and extent of the injuries.
  - c. Time, date, location and witness(es) of the incident.
  - d. Any indication that other children in the institution are or have been injured, abused, neglected, if so their names addresses and current location.
  - e. Any other information which might be helpful in establishing the cause of the injury, abuse and/or neglect.
  - f. Name, address and telephone number of the institution. Be sure to ask if the institution has an after-hours telephone number.
  - g. Name and address of the agency holding legal custody of the child/ren. This information is needed in order to notify that agency of the allegation.
  - h. Name and address of the child/ren's parent(s)/guardian(s). This information is needed in order to contact them regarding the allegation.
  - i. Name, address and present location of the alleged perpetrator(s). If the perpetrator(s) is a staff person(s), determine if the person(s) is still on duty or off duty. If the perpetrator(s) is another resident, determine where he/she is at the time you are obtaining this information.
  - j. Has the institution been apprised of the allegation and if so, what action(s) has been taken? Has the custodial county been notified? Have the parent(s)/guardian(s) been notified?
  - k. Has the victim(s) been separated from the perpetrator(s) by the institution?
  - l. Is the child/ren presently in danger of being abused or neglected?
  - m. If the child/ren has been injured, was medical treatment indicated? If so, has treatment been given or a plan for treatment been arranged? If treatment was indicated, but none given, planned or denied, in the reporter's opinion, would the injury constitute a medical emergency<sup>4</sup>
2. The investigation shall begin IMMEDIATELY. The child/ren must be seen within a MAXIMUM of 24 hours.
3. The investigating worker should obtain as much information, both historical and current, as possible regarding the child/ren, the facility and the perpetrator(s).
4. In the event there are multiple victims, more than one worker should go on site to interview the children.
5. The worker must have the following essential information to make a determination:
  - a. Detailed description of the incident.
    - (1) What were the circumstances surrounding the incident?
    - (2) What was the staffing pattern at the time of the incident?
    - (3) Who was present?
  - b. Detailed description of injuries.
    - (1) Medical assessment as to how they occurred.
    - (2) If the injuries were the result of physical management the worker should determine:

<sup>4</sup> Protection of Children in Institutional Care: A Guide for Public Children Service Workers, Ohio Department of Human Services, (Draft Manual), pp. 18-19.

- a) If physical management was necessary - child danger to self, others or property; or
    - (1) Could staff have foreseen that the child's reaction to a stressor might precipitate a crisis situation and taken preventive measures?
    - (2) Could professionally accepted techniques have been utilized by staff to de-escalate the situation so that physical management was not necessary?
    - (3) Was physical management used as punishment or discipline?
    - (4) Was the physical management done correctly and was the method used safe? INVESTIGATING WORKERS MUST KNOW PROPER RESTRAINT TECHNIQUES TO MAKE A DETERMINATION.
  - b) If mechanical restraints were used:
    - (1) Are mechanical restraints allowable in the facility on this child, are these specific devices allowable, and were the restraints utilized according to conditions set forth in regulations?  
The investigating worker should have access to and should thoroughly review regulations applicable to the facility. Regulations for residential child care facilities and day care are issued by the Colorado Department of Social Services. Regulations for developmentally disabled, mental health (which also applies to 2710 designated residential child care facilities), and youth services institutions and facilities can be obtained from the specific institution or the Colorado Department of Institutions.
    - (2) If psychotropic medication was used:
      - (a) Who administered?
      - (b) Who authorized?
      - (c) What was the dosage?
      - (d) Was administration of the drugs allowable under conditions set forth by statute and regulations? The worker should review mental health laws and regulations regarding the use of psychotropic drugs. Children in residential care are often victims of inappropriate medication. Mental health laws should be reviewed and the worker should check with an independent psychiatric consultant (nurse or M.D.) or other knowledgeable medical professionals regarding dosage.
    - (3) If injuries occurred but were accidental, was there lack of supervision or other negligence?
    - (4) If seclusion is involved, where, how long and why was the child secluded?
6. The investigative worker should notify:
- a. The identified department personnel per internal protocol.
  - b. The appropriate agencies and individuals.
    - 1) When alleged victim(s) is in residential care.
      - a) The county in which custody of the victim(s) is vested.
      - b) The counties holding custody of a child/ren in a residential facility when abuse or neglect is substantiated and/or there are concerns regarding child care practice.
      - c) If abuse occurs within a situation where only a limited number of children are exposed, e.g., in a cottage or classroom, the custodial counties of only these children must be notified.
      - d) When abuse occurs and it is felt it will affect all children within the facility, the custodial counties of all children must be notified.
      - e) The custodial county must notify the parent(s) of the victim(s) child/ren.
        - (1) After the child/ren has been seen and/or interviewed in cases in which there is an allegation but no injury or mild injury.
        - (2) Immediately if an injury requires medical treatment.
    - 2) When alleged victim(s) is in day care.
      - a) Parent(s) of the alleged victim(s) should be notified prior to the interview with the child/ren.
      - b) If there is a need to interview another child/ren, those parent(s) should be contacted prior to the interview.
      - c) Parent(s) of another child/ren in the facility or classroom should be notified when it is determined that the abuse/neglect is not

immediately unfounded.

They are to be advised in the following manner: "We are investigating an allegation of abuse or neglect in \_\_\_\_\_ day care center, has your child said anything?", or "Would you talk to your child about discipline, etc."

The worker cannot give any more information than: "We're investigating an allegation of abuse." A worker can not say that abuse has occurred nor can he/she identify a perpetrator, etc. If the parent(s) has questions, the worker should suggest that he/she talk to the director of the center.

- c. The State Department of Social Services, Licensing Section or other certifying authority.
- d. The local law enforcement jurisdiction.
- e. The director of the facility to advise that he/she will be investigating.
7. The interview with the alleged victim/s. **See Appendix I, Interviewing Techniques.**
  - a. The children should be interviewed in a setting which is as neutral as possible and where confidentiality can be maintained.
  - b. The child/ren shall never be taken off the grounds for the interview unless the investigating county department of social services has court ordered custody.
  - c. The alleged perpetrator(s) does not have the right and should never be allowed to be present during the interview with the child/ren.
  - d. The County Department of Social Services can, if necessary, obtain a court order to access the child/ren if the facility refuses as defined in Appendix C, **19-10-108, (c)(b), C.R.S., 1986.**
8. The worker should interview witnesses. The worker should determine if there are other victims not named in a report and **ASSESS THE SAFETY OF THOSE VICTIMS.** Interviews should be conducted with those victims immediately.
9. Interview of the alleged perpetrator(s) should be conducted after the interviews with the child/ren and witnesses. Workers should strongly consider a joint interview with law enforcement particularly if there is any possibility that criminal charges could be filed.
10. The transfer or suspension of the alleged perpetrator(s) should be assessed and discussed with the director of the facility. The director must make the final decision.

Should the director decide against transfer or suspension of the alleged perpetrator(s) and the worker determines that the child(ren) are in jeopardy, removal of the child(ren) should be pursued.

**D. Findings and determinations.**

1. An interview with the director or administrator of the facility should be conducted prior to leaving the site to:
  - a. Address any risk issues.
  - b. Inform him/her regarding immediate findings.
  - c. Inform him/her regarding the next steps in the investigation, and when he/she can expect Stage I of the investigation to be completed.
2. The Stage I investigator should make a determination whether the incident occurred independent of extenuating circumstances and whether the perpetrator is culpable and in what manner.
3. The Stage I investigator is responsible for filing the report with the Central Registry (CWS 59 and CWS 59A) for Child Abuse and Neglect when there is credible evidence that abuse or neglect has occurred.
4. The facility director or administrator should be notified immediately by telephone and in writing of the findings of the Stage I investigation.
5. The licensing or certifying authority should be notified of the findings of the Stage I investigation no later than five days after that investigation is completed. Any concerns regarding child care practice should be noted whether or not there is a finding of abuse and/or neglect. Appendix F, **Stage I Investigation Summary** form is to be utilized to summarize the findings. It is to be forwarded immediately to the appropriate licensing or certifying authority and the State Institutional Child Abuse and Neglect Advisory Committee.

Material sent to the above indicated should include a cover indicating that the material is confidential and is not to be disclosed in accordancy with 19-10-115, C.R.S., 1986.

6. Counties notified regarding the investigation should be notified regarding the finding of the Stage I investigation.



## V. STAGE II INVESTIGATION

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The purpose of the Stage II investigation is to determine the administrative culpability of a facility where an alleged incident of abuse has occurred and to determine if problems identified through the investigation are administratively re-dressable and/or if negative licensing/certification action should occur.

The process utilized in Stage II is very similar to that utilized in Stage I but with a focus on the part which the facility, i.e., its administration, policies, procedures and practice, played in relation to the alleged abuse. Just as the process is similar so are the knowledge, skills and abilities required to conduct the investigation.

Stage II investigators require a heightened sense of awareness to the reactions of facility staff to their investigation as its results could be perceived as having potentially punitive repercussions. Even though the Stage II investigation might be carried out simultaneously with Stage I, the purpose and focus of Stage II should be clearly delineated to facility administration and staff at the time the investigation is initiated.

A. Persons who are charged with the responsibility for Stage II of the investigation must have applicable skills and knowledge. See Appendix G, **Investigation Skills and Knowledge - Overview**, Ohio Manual, section covering "Protection of Children in Institutional Care: A Guide for Public Health Service Workers".

B. Procedures.

1. The county protective services worker should notify the licensing or certifying agency by phone immediately after a complaint has been filed.
  - a. In most cases this would be the State Department of Social Services Licensing Section.
  - b. In situations where no licensing or certification is required, such as the Division of Youth Services of the Department of Institutions, the executive director of the department should be notified.
  - c. There are other instances where it might be appropriate to notify the Colorado Department of Health, i.e., health care facilities licensed by the Colorado Department of Health.

Rationale: the advantage here is that Stage I and II investigations would be able to be better coordinated.

2. The Stage II investigator will receive a report from the Stage I investigator within five days of completion of the Stage I investigation.
3. The Stage II investigator should make a thorough review of the history and nature of any complaints involving that facility and the current written policy and procedures, program, and treatment modalities.
4. The Stage II investigator should begin the on-site investigation promptly after the receipt of the report from the Stage I investigator.
5. The investigator should evaluate the following:
  - a. Appropriateness of placements.
  - b. Appropriateness of treatment planning and practices.
  - c. Communication between the administrative supervisory staff with the child care staff and their content or method.
  - d. Communication between the child care staff and the content or method of communication.

- e. Interaction between the staff and the children.
  - f. Appropriateness of disciplinary actions.
  - g. Adequacy of the supervision of the children.
  - h. Policies and procedures vs. actual practice.
  - i. Hiring and screening practices.
  - j. Orientation and training of the staff.
  - k. Overall treatment program.
  - l. Nutritional program.
  - m. Physical condition of the facility as it relates to the incident. If there is a phone immediately available so that staff can call for backup; cleanliness, safety, repair and licensing violations.  
Investigators can make these determinations through interviews with administrators, child care and other staff, the Board if indicated, schools, mental health, agencies who have contact with the staff or residents, observation, and facility records and reports.
  - n. Supervision of the staff.
6. The investigator should conduct an exit interview with administrators to discuss any problems which require immediate attention and an overview of finds.
7. The investigator should prepare a corrective action plan and/or recommend negative licensing or certification action and complete the Stage II Investigation Summary Report sheet. See Appendix H, **Stage II Investigation Summary Report Sheet**.

## VI. CORRECTIVE ACTION

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Corrective action planning, negotiation and monitoring will be completed by the Stage II investigator. Corrective action recommendations will be formulated and discussed with the facility administrator. A written Recommendation Agreement will be developed and signed by all parties to the agreement. The contents of the agreement are shown below:

- A. A clear statement of the problems based on the findings of the investigation and the investigator's assessment of causative factors of abuse and/or neglect of the child/ren.
- B. Names and agency affiliation of person(s) responsible for carrying out the agreement.
- C. Corrective action recommendations to address each identified problem area.
- D. Problem solving objectives for each problem and corrective action recommendation.
- E. Tasks for each problem solving objective.
- F. Task assignments, time frames, and resources.
- G. A section itemizing the consequences for failure to carry out these tasks.
- H. A plan for monitoring progress.
  - 1. On site monitoring.
  - 2. Progress reports from the facility.

Upon the completion of a final inspection, a letter of advisement will be sent to the facility and copies forwarded to all persons and agencies previously notified of findings of abuse or neglect investigations. The letter will indicate:

- A. The success or failure at completion of the correction action plan.
- B. The consequences of the investigation.

## VII. PREVENTION

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The prevention of child abuse in out-of-home care settings must be a priority for administrative agencies as well as providers. Causative factors of abuse in out-of-home care are examined in the following as well as some recommendations which address these issues.

Residential placement facilities are not commonly subject to public scrutiny or independent assessments of maltreatment complaints. Causative factors of abuse in out-of-home care settings and some remedies are as follows:

### A. Inappropriate placements.

1. The county department of social services staff should give each facility permission to refuse to accept a child/ren.
2. The county department of social services staff should conduct a comprehensive history and a current evaluation on a child/ren before placement. All information regarding the child/ren's behavior, treatment needs, medical condition and care required should be shared with the facility in order to make a realistic evaluation of the appropriateness of the placement.

There have been incidents in the past of county staff failing to share critical information on a child/ren with a facility. There is a fear that the child/ren would not be accepted if it were known by the home or facility that the child/ren was an arsonist, etc. This is UNACCEPTABLE.

### B. Lack of training of child care staff.

Facilities are often in immediate need of a child care worker. In many instances, child care staff hired may not be experienced or trained.

Physical abuse in out-of-home care settings occurs in crisis situations. These circumstances require skilled crisis intervention techniques and occasionally physical management. The untrained child care worker may lack the skills to intervene effectively to prevent a physical confrontation. When there is a confrontation, the worker who is not trained to effectively and safely control the child/ren may cause an injury. A worker may strike out in self defense or attempt to physically manage the child/ren in such a way that jeopardizes the safety of the child/ren and/or the worker.

Those who are foster parents or child care workers in day care settings may inadvertently abuse in the course of punishing a child/ren. It is imperative that all substitute care givers be provided with the knowledge and skills necessary to provide quality child care. This is particularly important because all substitute care givers will be faced with handling a number of serious behavioral problems.

Currently, substitute care givers are not invited or notified of workshops that are not specifically directed to providers. Failure to notify or invite these individuals and facilities is often an oversight by the sponsor of the programs. Sometimes, however, care givers are not regarded as having professional status which is problematic. **PERSONS TREATED AS LESS THAN PROFESSIONALS CANNOT BE EXPECTED TO BEHAVE AS PROFESSIONALS.**

Substitute care givers including foster parents and group home parents should be notified or invited to workshops and encouraged to attend. Any workshop which is relevant to county child welfare staff or facility treatment staff is also relevant to care givers.

Substitute care givers should also be included on the mailing list of newsletters and other periodicals which provide informational materials related to children and/or announce the availability of workshops, current literature and films.

### C. Lack of administrative support for care givers.

In most situations in which there is abuse, neglect or poor quality of care in an out-of-home care setting, there is generally a lack of administrative support for care givers.

1. County department staff sometimes place a child in foster care and then become unavailable to these foster parents:
  - a. There is often a failure to keep foster parents advised of court status, length of stay, etc.
  - b. Sometimes there is a failure to provide critical information regarding specific behavior problems, medical problems, etc.

2. Treatment staff often fail to include direct care givers in treatment planning, or often input from the care giver is discounted. Treatment staff sometimes fail to communicate treatment plans and issues that surface during counseling sessions.

Treatment staff, including county department of social services staff, should involve care givers:

- a. In diagnostic decisions and treatment planning.
  - b. When staffing, efforts should be made to schedule the staffing at a time when care givers can be present and at a location convenient for the other professionals involved.
  - c. In information obtained in counseling sessions.
3. Treatment staff must:
    - a. Be accessible to care givers to discuss problems and to provide consultation.
    - b. Encourage and support this communication.
    - c. Recognize that care givers are professionals. Their input is valuable and should never be discounted. They spend far more time with the child/ren and know him/her better than any of the professionals involved.
  4. The same dynamics which lead parents to abuse their children are often operative in the out-of-home care setting:
    - a. The disturbed child/ren or adolescent(s) is sometimes literally "dumped" in their care.
    - b. They often have very little, if any, support from peers, treatment staff, or administrative staff.
    - c. They have to deal with the difficult child/ren or adolescent(s) with no relief.
    - d. Isolation.
    - e. Low self esteem regarding his/her role (as professionals discount the role and/or neglect the care giver).
    - f. May not have the support of family or friends in this area of his/her life. It is often these situations which lead to an abusive incident.
  5. Administrators must give care givers more priority. Clearly it is the care givers who have the greatest impact on the child/ren, thus, the success or failure of the program.
    - a. Peer support should be encouraged so that there is communication at all levels.
    - b. CARE GIVERS SHOULD BE REGARDED AND TREATED AS PROFESSIONALS. They should be afforded the same amount of respect and courtesy as other professionals.

D. Selection and screening of child care staff.

Because administrators and others who hire or certify care givers are often desperate for staff, they may fail to do an adequate job of recruiting, interviewing, checking references of previous employers, etc. in the interest of time. This has often resulted in a poor choice for the position.

The person may not have the skills or ability to work with the type of child/ren placed in the facility. The person may be emotionally, physically or sexually abusive. Although this sometimes occurs even when the process of recruitment and selection is thorough and generally effective, the risk is greatly reduced.

**PRIORITY MUST BE GIVEN TO THE DEVELOPMENT OF AN EFFECTIVE RECRUITMENT AND SELECTION PROCESS WHICH IS UTILIZED EVEN WHEN THE NEED FOR STAFF OR FOSTER HOMES IS DESPERATE.**

# APPENDIX A

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## INDICATORS OF CHILD ABUSE AND NEGLECT IN INSTITUTIONS

### PROTECTION OF CHILDREN IN INSTITUTIONAL CARE: A GUIDE FOR PUBLIC HEALTH SERVICE WORKERS

Ohio Department of Human Service, Draft Manual.

#### INDICATORS OF CHILD ABUSE AND NEGLECT IN INSTITUTIONS

The following indicators are provided to help county public children services agency workers recognize situations which may involve harm or risk of harm to a child and that **may** indicate that a child has been subject to abuse or neglect.

##### How to identify an abused child.

**Physical abuse** occurs when persons responsible for the child's care in an institution inflicts or allows to be inflicted upon a child, any bodily injury which **may** include, but is not limited to one of the following:

##### ***Marks and/or welts.***

Examples:

1. A staff member hits a child with a belt, or other object or push, trip, choke or throw a child, which leaves marks or welts on the child.
2. A staff member sits on a child or **inappropriately** restrains or inappropriately applies restraints on a child which results in bruises, welts, or other injuries.
3. A staff member ties a child to a chair or bed with rope or tape, which results in physical injury to the child.
4. A staff member allows, permits or encourages other residents to engage in the above mentioned actions against another child.

##### ***Cuts, punctures, scratches.***

Examples:

1. A staff member purposely scratches a child with his/her fingernails or other objects.
2. A staff member jabs a child with a sharp instrument or permits, allows or encourages other residents to do the same to another child.

##### ***Broken bones and skull fractures.***

Examples:

1. A staff member pulls a child out of bed, or hits a child's head against a wall which results in a broken bone or skull fracture.
2. A staff member hits a child with a bat or other hard object which may break a child's bone or cause internal injuries.
3. A staff member allows, permits or encourages other residents to engage in the above mentioned actions against another child.

##### ***Burns.***

Examples:

1. A staff member places a child in a hot tub of water, purposely burns a child with a cigarette, iron or grill or purposely places a child on or over a stove flame which results in any degree of a burn.
2. A staff member permits, allows or encourages other residents to engage in the above mentioned actions against another child.

##### ***Human bite marks.***

Example:

1. A staff member bites a child to teach the child not to bite others.

##### ***Internal injuries.***

Examples:

1. A staff member purposely gives a child alcohol or drugs which will result in sickness or internal injury. This also includes illegal selling of drugs to children.
2. A staff member gives a child prescription or psychotropic medication without the written approval of a licensed physician. This could result in sickness or internal injury.

**Suspicious scars** (on skin or bones which may indicate that the child is a victim of repeated or past abuses).

**General Abuse** occurs when persons responsible for the child's care engage in actions against a child which are unwarranted.

**Disciplinary actions.**

Examples:

1. A child is placed in isolation without being provided with ongoing monitoring.
2. A child does not receive a meal because he/she was acting up.
3. A child is not permitted to see his/her family as a means of punishment.
4. A child is denied clothing because he/she has damaged clothing already provided.
5. A child does not receive bedding because he/she has soiled the bed.

**Sexual abuse** occurs when persons responsible for the child's care at an institution commit or allow to be committed an act of sexual abuse against a child.

Examples: When a staff member:

1. Rapes a child or allows the child to be raped.
2. Engages the child in sexual intercourse, anal intercourse, fellatio, cunnilingus.
3. Manipulates child's genitals, buttocks, breasts.
4. Exposes his/her genitals to the child or allows a child to view another person's genitals for the purpose of exhibitionism.
5. Forces or knowingly allows a child to engage in sexual activity with other children or adults.
6. Forces, encourages or willfully and/or knowingly allows a child to engage in sexual activity with animals.
7. Entices, permits, encourages, compels, employs, or allows the child to act, model, or in any other way participate in, or be photographed for, the production, presentation, dissemination, or advertisement of any material or performance that is obscene.

**How to identify a neglected child**

**Neglect** of a child in institutional care includes any omissions of care to a child by persons responsible for their care or failure on the part of persons responsible for their care to exercise prudent care so as to jeopardize the well-being of a child in such a way that could lead to physical or emotional injury or damage.

**Inadequate or improper supervision.**

Examples:

1. A child(ren) is (are) left alone without adult supervision appropriate for the child's age, mental or physical condition and/or other special needs of the child. This means that the child is unable to care for his/her own or another's basic needs or is unable to exercise good judgment in responding to any kind of physical or emotional crisis.
2. A group of aggressive adolescent children are left alone by a child care worker who goes to talk to someone on the phone and a child is injured by another child.
3. A staff member leaves his assigned area and a child is sexually assaulted by another child.
4. A child care worker falls asleep or is drunk while on duty and as a result no one is available to respond to a child's needs or to protect the child.
5. A child is placed in an isolation room and staff do not monitor him/her and, as a result, the child hangs himself/herself.

**Danger to life, health, mental or social adjustment.**

Examples:

1. A child is exposed to danger to his life, health, mental, or social adjustment by staff failing to provide food, clothing, shelter, education, medical or surgical care or supervision.
2. Two children are fighting and the staff member purposely fails to intervene.
3. A child is not provided with his/her prescribed medication.
4. A child is allowed to self mutilate.

### **How to identify emotional abuse or emotional neglect.**

**Emotional abuse and emotional neglect** in institutional care should be considered when a person responsible for the child's care either by acts of commission or omission subjects a child to a negative atmosphere in which the child consistently feels unloved, unwanted, insecure, unworthy or otherwise lacks a positive relationship which is deemed essential for a person's physical, intellectual and emotional well-being.

**A Negative atmosphere** includes, but is not limited to the following:

Examples:

1. When a staff member **chronically** ridicules and/or degrades the child or his/her family, criticizes, threatens, ignores, or has an obvious preference for one child over another.
2. When a staff member uses treatment or punishment which is cruel such as tying up, locking in closet, taping mouth, or locking the child out of the living unit.

### **FACTORS THAT LEAD TO CHILD ABUSE AND NEGLECT BY INSTITUTIONS**

The institution itself can play a significant role in contributing to the abuse and/or neglect of children. Some key issues in deciding an institution's involvement and culpability in an incident of child abuse and/or neglect depend on whether or not the institution has made provisions for, trained or provided staff and, when appropriate, children and their families, with the institution's written policies, procedures and practices relating to the following:

1. Program description and population to be served;
2. Current service plan for each child, the engagement of each person responsible for service delivery, including child care staff, and the mechanisms for evaluating and updating service plans;
3. Rights of children and their families and a grievance/reporting system when they feel their rights have been violated;
4. Expectations of children and their families;
5. Discipline of children;
6. Problem management, physical restraint, time out and isolation;
7. Staffing patterns/coverage requirements which include action plans for staff absences, emergencies, planned or respite breaks from children and integration and assignment of new employees, especially child care staff;
8. Staff job descriptions, staff behavioral guidelines/expectations, staff evaluations, possible corrective or disciplinary actions for staff and staff grievance procedures;
9. Staff orientation and their ongoing training plan;
10. Supervision of all levels of staff, including chain of command for the institution according to the table of organization;
11. Required written/oral communications/reports and their time frames;
12. Medical care, routine and emergency, for children;
13. Safe keeping, transporting and dispensing of medications;
14. Use of psychotropic medications;
15. Reporting and maintenance system for hazardous conditions on grounds, in buildings or with equipment, including vehicles.

### **Common situations which can lead to institutional abuse.**

The following are some common day-to-day situations in an institution which, when handled inappropriately, can lead to abuse.

Examples:

1. When staff are not given training on how to control a child who is verbally or physically aggressive.
2. When staff are not provided with training and instruction on how to break up fights between children.
3. When staff are not provided with training on how to redirect a child who refuses to follow instructions.
4. When the institution fails to provide the type of program that is needed for the population they serve.
5. When an institution provides no means for staff, who have had a heated interchange with a child, to remove themselves from the situation in order to regain self control.



### **Common situations which lead to sexual abuse.**

The following are some common day-to-day situations in an institution which, when handled inappropriately, can lead to sexual abuse between children or between staff and children.

Examples:

1. There are no policies or procedures provided by the institution regarding staff removing a child(ren) from their living unit.
2. When the institution does not provide supervision to children during sleeping hours.

### **Common situations which can lead to institutional child neglect.**

The following are some common day-to-day situations in an institution which, when handled inappropriately, can lead to neglect.

Examples:

1. When the institution's staffing patterns and coverage requires persons to work longer shifts.
2. When the institution does not make provisions for supervision of child care staff on a unit and, as a result, staff sleep, are under the influence of drugs/ alcohol, or are engaged in other duties outside their work assignments while on the job.
3. When the institution lacks clear guidelines on the safekeeping of medication or the dispensing of medication, and as a result, there is misuse of medication by children.
4. When staff do not supervise children, ignore or fail to remedy a problem.
5. When staff are not trained on how to handle a medical emergency.

### **Common situations which lead to emotional abuse and neglect.**

The following are some common day-to-day situations, in an institution which, when handled inappropriately, can lead to emotional abuse or neglect.

Examples:

1. A child is chronically ridiculed.
2. Favoritism is shown towards one particular child.
3. When one or more children are picked out as being unlikeable and no one recognizes or handles these feelings or actions.
4. When promises are made to a child(ren) which cannot be fulfilled.

# Appendix B

## ALLEGED/SUSPECTED CHILD ABUSE/NEGLECT REPORT

Sample memorandum.

COLORADO STATE HOSPITAL  
Department of Institutions  
Division of Mental Health  
1600 West Twenty-Fourth Street  
Pueblo, Colorado 81003  
Phone (303) 543-1170

TO: Priscilla H. Gallegos, M.A., Director  
Clinical Support Services

FROM: \_\_\_\_\_  
(Team Leader/Designee)

DATE: \_\_\_\_\_

SUBJECT: Alleged/Suspected Child Abuse/Neglect Report

### I. Staff Member Section

Patient's Name \_\_\_\_\_ Case No.: \_\_\_\_\_

DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ Adm. Date: \_\_\_\_\_ Div./Team: \_\_\_\_\_

Incident Revealed To: \_\_\_\_\_ Date: \_\_\_\_\_

Time \_\_\_\_\_ During \_\_\_\_\_  
(activity)

Custody: Parents/DSS \_\_\_\_\_

Address: \_\_\_\_\_

Brief description of incident, including injuries, if any:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reported to Nursing Supervisor by: \_\_\_\_\_

Date and Time: \_\_\_\_\_

### II. Nursing Supervisor Section:

Action Taken (Nursing/Medical): \_\_\_\_\_

\_\_\_\_\_

Reported to Team Leader: \_\_\_\_\_  
(or designee) (name)

Date and Time: \_\_\_\_\_

Nursing Supervisor: \_\_\_\_\_

Date and Time: \_\_\_\_\_

III. **Team Leader Section.** (In the absence of team leader, the designated acting team leader must complete this section.)

Notification to director of clinical support services: \_\_\_\_\_

Reported to:

1. Pueblo County Department of Social Services

Caseworker \_\_\_\_\_

Date/time \_\_\_\_\_

2. Other County DSS: \_\_\_\_\_

Caseworker \_\_\_\_\_

Date/time: \_\_\_\_\_

Notification of Incident Given To:

	Name	Date/Time
Division Director	_____	_____
*CSH Personnel	_____	_____
**CSH Public Safety	_____	_____
Person Completing Section III:	_____	_____
	(Signature)	
	(Date)	(Title)

**Time frames and Reporting Order:**

1. Nursing Supervisor - Immediately
2. Team Leader or Designee - Immediately
3. CSH Public Safety Office - Immediately
4. Department of Social Services - Immediately
- 5.\* CSH Personnel Offices - Immediately
6. Director of Clinical Support Services - Within 4 hrs. (If after hours, report next working day.)
7. Submit this report to Director of Clinical Support Services - within 8 hrs. (If after hours, report next working day.)

\*Only for cases of alleged/suspected abuse involving a CSH staff member.  
\*\*Only for cases reported to have happened on CSH grounds or facilities.

## Appendix C

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19.10-108, C.R.S., 1986.

**19.10-108. Reporting procedures.** (1) Reports of known or suspected child abuse or neglect made pursuant to this article shall be made immediately to the county department or the local law enforcement agency and shall be followed promptly by a written report prepared by those persons required to report. The county department shall forward a copy of its own report to the central registry on forms supplied by the state department.

- (2) Such reports, when possible, shall include the following information:
- (a) The name, address, age, sex and race of the child;
  - (b) The name and address of the responsible person;
  - (c) The nature and extent of the child's injuries, including any evidence of previously known or suspected abuse or neglect to the child or the child's siblings;
  - (d) The names and addresses of the persons responsible for the suspected abuse or neglect, if known;
  - (e) The family composition;
  - (f) The source of the report and the name, address, and occupation of the person making the report;
  - (g) Any action taken by the reporting source;
  - (h) Any other information that the person making the report believes may be helpful in furthering the purposes of this article.
- (3) A copy of the report of known or suspected child abuse or neglect shall be transmitted immediately by the county department to the district attorney's office and to the local law enforcement agency.
- (4) A written report from persons or officials required by this article to report known or suspected child abuse or neglect shall be admissible as evidence in any proceeding relating to child abuse, subject to the limitations of section 19.10-115.

# Appendix D

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## LICENSING AND CERTIFYING AUTHORITY

### **Developed by the State of Colorado, Department of Social Services.**

1. Day Care Centers - Colorado Department of Social Services, Licensing Section.
2. Day Care Homes - County Department of Social Services.
3. Health Care Facilities - Colorado Department of Health.
4. Certified County Foster Care Homes - County Department of Social Services.
5. Child Placement Agency Foster Homes - Colorado Department of Social Services, Licensing Section.
6. Child Placement Agencies - Colorado Department of Social Services, Licensing Section.
7. Residential Child Care Facilities - Colorado Department of Social Services, Licensing Section.
8. Group Homes - Colorado Department of Social Services, Licensing Section.
9. Division of Mental Health Institutions - Colorado Department of Institutions and Colorado Department of Health.
10. Division of Mental Health - Colorado Department of Institutions and Colorado Department of Health.
11. Division of Youth Services Institutions - Colorado Department of Institutions and Colorado Department of Health.
12. Division of Youth Services Group Homes - Colorado Department of Social Services, Licensing Section.
13. Division of Developmental Disabilities Institutions, Community Center Boards FCFMR - Colorado Department of Institutions and Colorado Department of Health.

# Appendix E

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## PROCEEDING WITH THE INVESTIGATION

### PROTECTION OF CHILDREN IN INSTITUTIONAL CARE: A GUIDE FOR PUBLIC HEALTH SERVICE WORKERS

Ohio Department of Human Services, Draft Manual.

Note: Some modifications to this draft manual have been made based upon experience of the Colorado Department of Social Services.

**PROCEEDING WITH THE INVESTIGATION:** The worker begins the investigation by conducting an entry interview with the director of the institution or his/her designee. The worker should explain his/her role and mandate to investigate allegations of abuse and/or neglect, what activities he/she will engage in as part of the investigation, describe the nature of the report (the identity of the referral source shall not be revealed) and then ask the administrator the following:

1. What he/she knows about the incident?
2. If there are any agency reports regarding the incident?
3. What action(s) the institution has taken (i.e., relieve the alleged perpetrator of his/her job responsibilities, separate the child from the alleged perpetrator(s), obtain a medical examination?)
4. The name(s) of the staff on duty at the time of the incident?
5. The person(s) responsible for the alleged child victim and the alleged perpetrator at the time of the incident?

**Interviewing the Alleged Child Victim(s):** In all reports of child abuse and/or neglect the alleged child victim is interviewed. The purpose of the interview with the child is to determine his/her side of the story and provide him/her with an opportunity to give his/her account of the incident. The interview also provides the worker with the opportunity to develop a sense of trust with the child by:

- 1 Letting him/her know why the worker is there.
- 2 Giving him/her an idea of what will happen during an investigation and the confidentiality given to his/her statements.
- 3 Reassuring the child that it was a good idea to talk to the worker and report the incident (if the child made the report).
- 4 Empathizing with the child.

During the course of the interview with the child, the worker tries to connect the incident to specifics which have meaning to the child (i.e., the incident happened after dinner); determine if there were any witnesses to the incident; and depending on the nature of the allegations, other information on institutional life.

**Physical Structure:** The design and layout of the institution can increase the likelihood of abuse and/or neglect of a child by staff or other residents and a worker should look at the location where the alleged abuse and/or neglect occurred. By observing the physical structure of the institution the worker should be able to develop an understanding of how the abuse and/or neglect occurred and this should assist the worker in recommendation planning following the investigation.

The sleeping quarters of the residents can be at a distance from the staff's room where he/she would not be able to hear a disturbance or a child crying out for help. Visual oversight of children would require staff to make constant tours of all resident rooms during the night.

Design and layout not only includes an awareness of physical location of rooms but also includes accessibility to either staff or phones when an emergency exists. When observing the location where the incident was to have occurred the worker should look at where telephones are located and should determine how far away another staff person was who could have been able to assist staff or children.

The worker should also look at what objects are in the room where the incident took place (i.e., dangerous or sharp objects, or furniture in the room that blocks staff or child residents view of what is going on in that room).

### **Case Example**

To illustrate some of the complexities that can be experienced in the investigation, the following example is offered.

**Overview:** A report was received regarding the alleged physical abuse of one child, John, by another child, Jim. The investigation found the situation to unfold as follows:

**Event Participants and Maltreatment:** Jim had been angry and irritable and had focused his aggressive behavior on John. The two had carried on verbal and physical sparring all day. The living unit staff member, who was working the last four hours of a double shift, had not attempted to intervene, redirect or separate the boys or to seek assistance in dealing with them. His co-worker had left several hours earlier to assist in taking a sick child to the hospital. The unit staff person sent the group of eight boys, ages 10 to 12 years, unaccompanied across campus (1/8 of a mile) to the recreation building. In their journey, Jim enlisted the aid of four boys to harass John.

After getting the boys started in an activity, the recreation worker went down the hall, through a door to use the building telephone which was housed in an office. During the ten minute telephone call, he thought he could distinguish loud voices and banging that were beyond the sounds of boys at play. He concluded fighting. In his attempt to separate the boys, he grabbed Jim by the neck and hair and in their struggle Jim fell on a table edge. This resulted in Jim receiving several cracked ribs, some loss of hair and scratches across the neck and back. Ned, who had not been fighting, received a cut above his eye when hit by a chair thrown by another child, Bob. When knocked to the floor by Jim, John had received a bloody nose and a mild concussion.

**Sources of Information:** All alleged victims, alleged perpetrators and witnesses were interviewed. For physical abuse, John was Jim's alleged victim, Ned was Bob's alleged victim and Jim was the recreation worker's alleged victim. All children in the group were considered alleged victims of neglect.

Related institutional policy and procedures were reviewed as were appropriate unit incident logs, child case records, medical records, involved staff records and training records. Others were interviewed when deemed appropriate. This included supervisors, nurses, social worker and the institutional administrator.

**Policy, Procedures and Practice:** The unit staff person felt he needed a break away from the boys and called the recreation worker stating only that he would not be accompanying the boys to the recreation building. Not going with the boys was in violation of written policy and procedures, but was informally accepted practice, if not abused. Per policy, the unit staff person's absence at this time aggravated the risk level for the boys. In contrast to his training and the policies and procedures, he had not made any efforts to redirect the boys' behavior, to log the day long aggressive behavior of Jim, or to share information with the recreation worker or Jim's social worker. His personnel folder and supervisor documented his continuing problems in dealing with aggressive behavior, seeking assistance and following policy and procedures. While weekly supervisory conferences are required by institutional policy, one had not been convened for four weeks. On-the-spot mini-conferences had also been limited.

There were written policies and procedures regarding physical restraint; however, the recreation worker had not received training and was only made aware of the existence of the policy and procedures in the four hour orientation he received three months ago. He never concerned himself with the training because he felt he could handle the boys.

While interviewing the social worker, it was learned that Jim was receiving therapy outside the institution. The social worker had met with the therapist during the week prior to the incident and had planned to share information with staff during the unit staff meeting that would have occurred two days after the incident. Jim's therapist had indicated that Jim seemed to be under a great deal of stress and his feelings were highly charged. The therapist felt that Jim might have bursts of aggressive/acting out behavior and that he would need firm structure until he was able to regain self control. Jim's record had a copy of the therapist's report. There was no policy regarding time frames for sharing such critical information with appropriate staff.

In checking the medical records, it was felt the boys received appropriate, timely care.

The institutional advocate had made the original report based on a conversation with John. John's recanting of the situation had been fairly detailed concerning actors and events surrounding the incident. The other events and circumstances beyond John's injury were viewed by the advocate as issues to be handled within the institution.

**Physical setting:** Due to the hills and the campus landscaping, the unattended boys would have been out of visual range for most of the distance between the living unit and the recreational unit, the location of the activity room and the location of the office with the phone, the investigation conclusion was that one staff person could not have responsibly supervised or obtained assistance in an emergency without leaving the boys at greater risk.

**Summary:** From this illustration, it is apparent that not only were there direct acts of abuse of commissions and neglect of omissions present, but there were indirect factors, for which the institution and staff could be held accountable. These factors would need to be addressed in the recommendations. For example, to prevent other such events, the facility would need to:

1. Assure compliance to its written policies and procedures,
2. Develop and follow policies and procedures relating to timely sharing of critical information concerning a child/ren's treatment or program needs;
3. Discontinue informally approved practices;
4. Devise a communication system in the recreation building that does not leave children unattended or staff unable to get help without leaving children at risk;
5. Provide or assign sufficient staff to eradicate extended duty or lack of appropriate breaks from children;
6. Provide staff training to equip staff with skills/knowledge needed to deal with children; and
7. Increase staff's ability to identify and report child abuse and neglect.

The case example illustrates the need for careful selection of agency investigative staff. The investigator(s) must have a clear understanding of the abuse and neglect statute and Colorado Department of Social Services rules and be confident in the appropriate handling of the authority granted in statute and rules. Often the agency conducting the investigation has a direct or indirect relationship with the institution either because it operates or places children in the facility. The agency investigator must be able to handle conflict of interests issues which may arise as they conduct their social investigation.

**INVESTIGATION - OVERVIEW:** The investigation conducted by the county public children services agency is a fact finding process in which the worker, in response to an allegation of child abuse and/or neglect, gathers information through interviews, observations, and documents/records in order to: 1) assess the need for emergency intervention; 2) evaluate the safety of the child or other children in the institution; 3) make a case determination and 4) determine the need for a recommendation agreement. The worker is responsible for determining the following:

1. Whether abuse and/or neglect actually occurred.
2. The circumstances surrounding the injury, abuse and/or neglect.
3. The cause of any abuse and/or neglect.
4. The person or persons responsible.
5. The need to protect the child victim or other children in the institution from harm.
6. Whether the administrative authority or institutional staff are culpable, and if so, in what manner?



**Source of Information:** The worker must be aware of the various sources of information that can assist him/her in making a determination about whether there is evidence that child abuse and/or neglect occurred. A determination of child abuse and/or neglect may be made using information provided:

1. During interviews with the administration.
2. During interviews with the alleged child victim(s).
3. During interviews with the alleged perpetrator(s).
4. During interviews with witnesses to the incident.
5. By institutional incident reports, institution's written policies and procedures, institutional logs, medical reports, personnel records, school records or other institutional records.
6. By worker's own observations of the institution, staff/resident interactions, resident/resident interactions.

The evidence collected by the worker during the investigation could include the following:

1. Real evidence consisting of documents (i.e., incident reports, medical reports) and photographs such as X-rays, pictures showing a child's injuries, the environment of the institution.
2. Direct evidence comes from firsthand knowledge of events. It can include statements describing what an observer saw, heard, said and did.
3. Hearsay evidence is secondhand information. The statement, "Mrs. Jones told me she heard Mr. Wilson threaten John," is an example of hearsay evidence.
4. Circumstantial evidence is indirect proof of facts. For example, if medical opinion holds that a child's injuries could have been sustained by accident, in the manner detailed by the alleged perpetrator(s), we may be able to infer that this person(s) was responsible for the abuse and/or neglect occurring.

# Appendix F

## STAGE I INVESTIGATION SUMMARY

Developed by the State of Colorado, Department of Social Services

NAME OF VICTIM: \_\_\_\_\_  
NAME OF ALLEGED PERPETRATOR: \_\_\_\_\_  
DATE OF INCIDENT: \_\_\_\_\_ DATE REPORTED: \_\_\_\_\_  
NAME OF FACILITY: \_\_\_\_\_  
ADDRESS OF FACILITY: \_\_\_\_\_

### TYPE OF FACILITY:

_____ DAY CARE CENTER	_____ PRIVATE HOSPITALS
_____ DEVELOPMENT DISABLED REGIONAL CENTER	_____ PRIVATE SCHOOL
_____ DIVISION OF YOUTH SERVICES FACILITY	_____ PUBLIC SCHOOL
_____ RECEIVING HOME	_____ RESIDENTIAL CHILD CARE FACILITY
_____ FAMILY FOSTER HOME	_____ STATE HOSPITAL
_____ GROUP HOME/CENTER	_____ OTHER
_____ HEAD START	

INVESTIGATOR'S NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_  
DATE INVESTIGATION OCCURRED: \_\_\_\_\_  
COUNTY DEPARTMENT OF SOCIAL SERVICES: \_\_\_\_\_  
INVESTIGATING LAW ENFORCEMENT OFFICER: \_\_\_\_\_  
NAME OF INVESTIGATING LAW ENFORCEMENT DEPARTMENT: \_\_\_\_\_

SUMMARY OF INCIDENT: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CONCLUSION OF STAGE I INVESTIGATION: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

FACTORS RELEVANT TO CULPABILITY OF THE FACILITY IN THIS INCIDENT: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CORRECTIVE ACTION RECOMMENDATIONS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Copy: State Department of Social Services, Licensing (\_\_\_); Executive Director, Dept. of Institutions (\_\_\_); Colorado Dept. of Health (\_\_\_); Local School Board (\_\_\_); County Department of Social Services (\_\_\_); State Institutional Child Abuse and Neglect Advisory Committee (\_\_\_); Facility (\_\_\_).

# Appendix G

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## INVESTIGATION SKILLS AND KNOWLEDGE - OVERVIEW

### PROTECTION OF CHILDREN IN INSTITUTIONAL CARE: A GUIDE FOR PUBLIC HEALTH SERVICE WORKERS

Ohio Department of Human Services, Draft Manual.

Note: Some modifications to this draft manual have been made based upon experiences of the Colorado Department of Social Services.

**INVESTIGATION SKILLS AND KNOWLEDGE - OVERVIEW:** Institutions have functioned as a closed system with their own established policies and procedures for operating the institution and for defining their contacts with the world outside of their setting. Once a report is made to the county public children services agency about an allegation of child abuse and/or neglect, the institution is "forced" to open its system for outside review and scrutiny.

Institutional personnel may view the children services investigation and/or the law enforcement investigation as an attack on themselves and their methods of operation. They may feel that they will lose their creditability for caring for children in the community just because of "this one report" - which in reality might occur. Due to the above-mentioned factors, it is essential for the county public children services agency to consider what skills and knowledge a worker needs to possess when conducting investigations of abuse and/or neglect occurring in institutional settings.

Investigation of allegations of institutional child abuse and/or neglect require different investigative skills than one normally possesses and uses when investigating allegations of an intra-familial situation. When investigating allegations of abuse and/or neglect occurring in institutional settings, the worker needs to examine the allegations(s) within the context of the policies and procedures of the institution, within the environmental milieu of the institution, as seen from the perspective of both staff and children, and with an added awareness of the physical structure of the institution. All questions asked of staff, the alleged child victim(s), the alleged perpetrator(s), the institutional administrator, and other institutional personnel should be set within this new frame of reference.

**STAFF ASSIGNMENT:** When selecting staff to conduct investigations of alleged child abuse and/or neglect in institutions, depending upon the size of the agency and number of available staff, the director/executive of the county department of social services agency may want to consider the following factors: the investigation may involve inter-agency relationships and working with various levels of institutional, state and third party law enforcement staffs.

While the report may appear to involve a single alleged victim and perpetrator, the investigation may very well broaden to include multiple victims and perpetrators, involvement by several levels of institutional staff, or program, policy, procedure, practice or training issues. In instances of allegations of abuse and/or neglect involving group care for children, there is also the possibility of having to deal with the news media. As with other abuse and/or neglect investigations, there is the possibility of court activity. When children of other child placing agencies are involved, there will need to be some coordination of efforts. Parents of involved children will need to be notified and, as necessary, engaged.

**INVESTIGATION KNOWLEDGE AND SKILLS:** The investigator needs to have a knowledge base concerning the operation of institutions. This knowledge will assist them in assessing a reported isolated allegation within a broader context which could include other actors, events or institutional factors.

Those persons conducting the investigation must be cognizant of the feelings of children, staff and administrator(s), and consciously work to reduce any anxiety, fear or resistance which may be present.

The assessment of investigatory information and case determination will require the capacity to fully understand the actor(s), event(s), and setting(s) in which the alleged maltreatment occurred. Translating the case determination into recommendations, when required, and negotiating activities to achieve the recommendations with the institutional administrator will require a high level of professional skill and diplomacy.

Workers who are assigned the responsibility of conducting investigations of abuse and/or neglect occurring in institutional settings should possess the skills such as

interviewing, information locating/processing, evaluating information, and developing recommendation agreements with the institution and its licensing authority.

**Information Locator/Processing - Knowledge and Skills:**

1. Knowledge of information sources within the institution and from persons affiliated or contracted by the institution to assist in making determinations (i.e., institution's unit logs, incident reports, policies and procedures of the institution, institution/staff manual).
2. Knowledge of the institution's methods of reporting injury of a child.
3. Familiarity with procedures for dissemination of information within the institution.
4. Knowledge about how to document interviews, records and activities.

**Evaluation of Information - Knowledge and Skills:**

1. Knowledge about different types of evidence and weight carried by each.
2. Ability to discern facts from impressions.
3. Ability to present information for case conferences, for case determination and recommendation planning.

**Recommendation Planning - Knowledge and Skills:**

1. Knowledge of institutional policies and procedures.
2. Knowledge about making service plans.
3. Knowledge of time limits to establish with the institution when developing recommendation agreements.
4. Knowledge about court process.
5. Knowledge and competence in applying guidelines regarding case requiring adjudication.
6. Knowledge of minimizing hazards of group living for children and knowing what these hazards are.
7. Interpersonal skills.
8. Skills in working with other agencies (i.e., licensing authority for institution).
9. Professional judgment and skill in estimating the time required to achieve the recommendation agreement by the institutions.

Workers may already have some of the identified skills. Skills and knowledge that relate specifically to institutions can be attained by attending specialized workshops on: use of medication with children, passive physical restraint procedures, and use of seclusion and time-out rooms.

**A. KNOWLEDGE**

1. Knowledge of all laws and regulations which would have relevance.
2. Knowledge of the certifying or administrative agency's policy regarding child care, reporting of abuse, etc.
3. Knowledge of the policies of the facility.
4. Knowledge of the behavioral characteristics of the population which the facility serves and child and adolescent growth and development.
5. Knowledge of the facility's philosophy regarding child care as well as the programmatic design and treatment modality.
6. Current knowledge regarding treatment modalities and program practices acceptable by current standards.
7. Basic knowledge concerning the operation of a residential, institutional or partial care facility.
8. Knowledge of physical restraint procedures.
9. Knowledge of uses of various medication (i.e., psychotropic medication).
10. Knowledge of time out and seclusion procedures and their uses with children.
11. Knowledge of legal requirements on release of information.
12. Knowledge of information sources within the institution and from persons affiliated with or contracted by the institution to assist in making determinations (i.e., institution's unit logs, incident reports, policies and procedures, and institution/staff manual).
13. Knowledge of the facility's methods of reporting injury of a child.
14. Familiarity with procedures for dissemination information within the institution.
15. Knowledge of how to document interviews, records and activities.
16. Knowledge of how to minimize hazards of group living for children and what these hazards are.

## B. SKILLS

1. Interviewing skills.
2. Information locating/processing and evaluating, ability to analyze information.
3. Evaluating information.
4. Professionalism and diplomacy.
5. Negotiating skills.
6. Skills in eliciting information from young children (i.e., use of dolls), adults who may have greater administrative responsibility than the investigator does within their respective agency.
7. Skills in eliciting information, and ability to support and enable persons to share information, using their "authority" role as a last resort.
8. Ability to provide information to persons interviewed.
9. Ability to explain legal requirements in terms meaningful to persons being interviewed.
10. Ability to discern facts from impressions.
11. Diagnostic skills.
12. Understanding of the dynamics of institutional life.
13. Ability to use authority to access institution's reports and records.
14. Ability to present information for case conferences, for case determination and recommendation planning.
15. Interpersonal skills.
16. Skills in working with other agencies (i.e., licensing authority for institution).

# Appendix H

## STAGE II INVESTIGATION SUMMARY REPORT SHEET

Developed by the State of Colorado, Department of Social Services

VICTIM'S NAME: \_\_\_\_\_ ALLEGED PERPETRATOR: \_\_\_\_\_  
NAME OF FACILITY: \_\_\_\_\_ DATE OF INCIDENT: \_\_\_\_\_  
DATE OF STAGE II INVESTIGATION: \_\_\_\_\_ NAME OF STAGE II INVESTIGATOR: \_\_\_\_\_  
NAME OF INVESTIGATING AGENCY: \_\_\_\_\_ WAS ABUSE FOUNDED? YES \_\_\_ NO \_\_\_

### SUMMARY OF RESULTS OF STAGE II INVESTIGATION: (Please comment as appropriate on factors listed below)

Policies and Procedures of Facility: \_\_\_\_\_

Discipline Policies: \_\_\_\_\_

Relevant Statute, Rule or Regulation (Violation): \_\_\_\_\_

Staff Training: \_\_\_\_\_

Staffing Patterns: \_\_\_\_\_

Staff Hiring and Screening: \_\_\_\_\_

Supervision: \_\_\_\_\_

Prior Reports: \_\_\_\_\_

Nature of Population: \_\_\_\_\_

Appropriate Placement for the Child: \_\_\_\_\_

Supervision of Children: \_\_\_\_\_

Response of the Facility: \_\_\_\_\_

Response of the Child: \_\_\_\_\_

Response of the Perpetrator: \_\_\_\_\_

Vulnerability of Other Children At Risk: \_\_\_\_\_

Physical Condition of Facility: \_\_\_\_\_  
\_\_\_\_\_

**LIST CONTACTS AND ACTIVITIES INVOLVED IN THE INVESTIGATION:** (Please identify individuals interviewed by title where applicable): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**RECOMMENDED CORRECTIVE ACTION:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Copy: State Department of Social Services, Licensing (\_\_\_); Executive Director, Dept. of Institutions (\_\_\_); Colorado Dept. of Health (\_\_\_); Local School Board (\_\_\_); County Department of Social Services (\_\_\_); State Institutional Child Abuse and Neglect Advisory Committee (\_\_\_); Facility (\_\_\_).

Form #CDSS-IA/02, 4/11/86:cj

# Appendix I

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## INTERVIEWING TECHNIQUES

Specialized training in the Investigation of Out-of-Home Child Abuse and Neglect, by Constance Ryan, Gregory Smiles, Michael Nunno, copyright 1983, Family Life Development Center, Cornell University.

### A. The interviewing process

1. Witnesses can be key figures in determining whether an incident occurred. Their statements should be matched with the victim's and the alleged perpetrator's statements. It may be necessary to ask witnesses specific questions, for example, to explain a restraint technique. The credibility of a witness should always be assessed.
2. Other staff members or residents, even though they may not have observed the incident, should be interviewed. They may be able to provide relevant information about the victim or alleged perpetrator, such as when they were last seen or whether any marks were on the victim prior to the incident. This is especially true of incidents involving a child with learning disabilities who may not be able to make his or her own statement.

### B. Interviewing the victim

1. Consider the victim's age, verbal ability and handicaps in determining your approach to the interview. Also consider the impact of an interview on the child and his or her relationship with the alleged perpetrator. Be aware of the possibility of staff retaliation, or future mistrust of the child. Be aware that kids can take advantage of the special attention of an interview or use the opportunity to retaliate against the staff.
2. The interview will establish the victim's side of the story, and allow you to observe the child. The child also becomes informed and aware of what is happening.
3. It is important, when interviewing children, to get them to trust you. This can be accomplished by:
  - letting them know why you are there;
  - reassuring them that it is correct for them to be talking to you;
  - letting them know you understand them and are "with" them;
  - empathizing with them.
4. Let the child tell the story of the event in his or her own words without interruption. Then seek clarification, by asking questions using the child's vocabulary, to answer the questions: who, what, when, where, why and how.
5. Connect the incident to specifics which have meaning to the child, for example, by asking time or location oriented questions: "did this happen after dinner?" or "did this happen in your bedroom?"
6. Find out whether or not there were any witnesses, either other residents or staff members.
7. Depending on the nature of the allegation, you may want to ask some of these questions:
  - Does the staff use corporal punishment? under what circumstances? what kind? how often?
  - What kind of restrictions are used at this facility?
  - Have you ever been placed in seclusion? why? for how long?
  - Are physical restraints used at this facility? under what circumstances? what kind? how often?
  - How often do you get visiting privileges?
  - How often are you able to go home for a weekend?
  - What happens if someone runs away?
  - What happens if someone is fighting?
  - What happens if someone curses at a staff member?
  - What kind of recreation facilities does this institution offer?
  - How much heterosexual activity goes on here? how much homosexual activity goes on here?
  - What do all the staff members do here? is there any difference when the night shift takes over?
  - Why are you here?



NOTE: The questions listed in item 7 above may appear to involve general program concerns rather than dealing specifically with the victim. However, they can relate to the causes of specific incidents of abuse or neglect as demonstrated by the following examples.

- Because there were no education or recreation activities, the child may have acted out due to boredom.
- The child may have become aggressive because of an unfair punishment, such as the denial of visiting privileges, being placed in seclusion or the withholding of a meal.
- Frequent occurrence of inter-resident homosexual or heterosexual behavior may indicate a supervision problem at the facility.
- Practices may be occurring at the facility which in themselves are not abusive, but may have the potential of causing physical injury or emotional abuse.
- Techniques labeled "appropriate physical restraint" may, in fact, be inappropriate or abusive and present potential harm to the child.

C. Interviewing the alleged perpetrator

1. Interviewing the alleged perpetrator is a very delicate matter that requires care and tact. The purpose of this interview is to gather facts and allow the alleged perpetrator to present his or her side of the story.
2. The investigator should stress that the allegations are unfounded at this point and that the investigative process will gather the necessary facts to enable a determination to be made.
3. The outcome of the investigation may bear serious consequences for the alleged perpetrator should the allegations be substantiated. These consequences include loss of employment, damage to personal and professional reputation, greater difficulty in securing future employment in the field of child welfare services, and the possibility of criminal indictment.
4. The investigator legally cannot assure the alleged perpetrator that the information he or she provides will be held confidential or will not be used in subsequent criminal prosecutions or administrative actions against them. Therefore, the refusal of the alleged perpetrator to participate in the interview can be considered as an exercise of his or her rights and should not be construed as an indication of guilt.
5. At the start of the interview, introduce yourself and identify the agency you represent. Explain your role or legal responsibility. You are collecting information to determine if child abuse or neglect has occurred. You are there to assess the potential for harm and to protect the child. You are not interested in targeting blame, although information you have gathered may be used in court.
6. Be nonaccusatory - at this point the allegation is unproven. For example, rather than say, "I'm here because you hit resident John Doe," a better statement would be, "I'm here because I have received a report that resident John Doe may have been hurt."
7. When appropriate, show empathy. You might say, "Yes, I can understand how difficult it must be to care for so many of these kids." Be careful, though, that your empathy does not compromise your objectivity. Use your expertise, authority and understanding of children in residential placements to convey your understanding of how abuse occurs, stressing that, in fact, abuse must stop.
8. Give the alleged perpetrator responsibility and authority; he or she is "expert" on the institutional environment. Give him or her respect and space to explain the incident according to their own perceptions. After the alleged perpetrator has given his or her statement, go back and ask questions.  
Find out who, what, when, where, why and how.  
Find out if there were any witnesses.  
If this statement does not coincide with statements made by the victim or witnesses, ask questions to fill in the gaps. If there are obvious, suspicious differences in the stories, go back and attempt to clarify them; a complete report, even if it is late, is better than an incomplete one.
9. Explain that it may be necessary to return at a later date to ask more questions.
10. Depending on the nature of the allegation, you may want to probe into these subject areas and ask some of these questions:
  - a. Regarding Discipline - What form was used in this incident? What forms are used in general? Is corporal punishment ever warranted and if so, under what circumstances? Do children discipline other children?

- b. Regarding Seclusion - Was seclusion used in this incident? How long was he or she in seclusion? In general, when and how is seclusion used as a discipling device? How long does a child normally remain in seclusion? What does the staff do after the seclusion period ends? What kind of written documentation is there regarding seclusion?
- c. Regarding Physical Restraint - What was the child doing that made it necessary to use physical restraint? Could you explain the technique you used to restrain the child? Were you angry when you restrained the child? Did you try any other intervention technique, such as talking the child down, before physical restraint became necessary? What did you do after the restraint incident? In general, how often is physical restraint used here?
- d. Regarding Mechanical Restraint - What device (handcuffs, camisole, leg restraints, etc) was used? Was it authorized by a supervisor or doctor? How long was the child in it? How often was the child checked while in the restraint? Is there documentation of the child's condition while in the restraint?

NOTE: Special considerations regarding neglect allegations.

Most cases of institutional neglect will involve the physical or sexual attack of a resident by another resident or residents. While inter-resident aggression can be common in certain facilities, it should occur only on a limited basis. The investigator should also keep in mind that if supervision is appropriate, these acts should not produce serious injury, since staff is required to intervene in such circumstances. Though institutional neglect usually involves issues concerning appropriate supervision, it may also occur in other situations not involving inter-resident aggression. For instance, it may occur when a staff member leaves an individual child alone and a preventable accident occurs, for example, a child is scalded while taking a bath. Neglect also includes things such as the lack of medical care and inadequate food and clothing. The main issue being investigated in situations of institutional neglect is staff accountability, and sometimes program responsibility.

On institutional neglect referrals, the case worker will usually have to start the investigation with the facility director or a supervisor. Explain the referral, giving dates and time, if possible. Ask the director or supervisor what he or she knows about the incident and request any reports he or she may have about it. Obtain the name of the staff member or members who were on duty at the time of the incident, in particular, the employee who was directly responsible for the victim and the alleged perpetrator.

Depending on the nature of the neglect allegation, ask these questions of the staff member directly responsible for the child:

- What were you doing at the time of the incident? Was that your assigned duty?
- If the incident occurred during sleeping hours, did you make regular checks? Are regular checks normally made?
- Did you know the incident was occurring?
- What did you do about it? How did you try to stop it?
- How many children were you responsible for at the time?
- Was any other staff around?
- What did you do after you learned about the incident (medical treatment, separate residents, etc.)?
- Does fighting between residents occur often?
- How extensive is homosexual or heterosexual activity?

D. Interviewing other appropriate institutional staff

1. This is listed as a separate category because of the importance of contacting other institutional departments, such as the medical department, that can often provide the deciding factor as to whether an allegation of abuse is or is not substantiated.
2. Ask the medical staff if they saw the child? Were there injuries? What kind? How was the child treated? If appropriate, obtain the medical history of the child.
3. Ask the supervisor of residential staff or the director of the facility to assess the past job performance of the alleged perpetrator. Has he or she been involved in other incidents? Have there been previous problems with this particular resident (the victim)?
4. Ask the social work department, education department, and psychology or clinical department if people in these departments can provide information on the specific incident. If not, they can be used to obtain a history of the child's general adjustment while at the facility.