Clayton County Multidisciplinary Investigation and Prosecution of Child Abuse, SexualAbuse, and Sexual Exploitation Protocol and Clayton County Adult Sexual Assault Protocol

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CLAYTON COUNTY CHILD ABUSE PROTOCOL

I. Introduction

This Child Abuse Protocol (CAP) is established for Clayton County[1] consistent with O.C.G.A. § 19-15-2 for the investigation and prosecution of alleged cases of child abuse.

WHAT IS THE PURPOSE OF THE CAP? The purpose of this protocol is to ensure coordination and cooperation between all agencies involved in a child abuse case so as to:

1. Increase the efficiency of all agencies handling such cases;
2. Minimize the stress created for the allegedly abused child by the legal and investigatory process; and
3. Ensure that more effective treatment is provided for the perpetrator, the family, and the child, including counseling.

This protocol outlines in detail the procedures to be used in investigating and prosecuting cases arising from alleged child abuse and the methods to be used in coordinating treatment programs for the perpetrator, the family, and the child.[2] As agencies coordinate and collaborate through a multi-disciplinary approach, communities can identify and implement solutions to issues related to the care and well-being of children.

TO WHOM DOES THE CAP APPLY? Children (under the age of 18) who may be victims of child abuse.

WHO IS BOUND BY THE CAP? All statutorily mandated committee members and signatories. The protocol is a guideline, not intended to be legal evidence of a standard of care, and compliance or noncompliance therewith is not intended for use in trial or court as relevant evidence. In case of any interpretation or conflict, or for requirements not addressed herein, the law will always take precedence.

WHAT CAN I EXPECT FROM THE CAP? The CAP can:

- Reduce trauma to children by improving interagency coordination to reduce the number of times a child has to tell his/her story of abuse.
- Improve the opportunity for children to heal from trauma by encouraging the system to be responsive and accountable.
- Delineate professional roles and responsibilities.
- Establish standards for points of contact, methods of contact, and purposes of contact between these agencies.

[1] When a judicial circuit is composed of more than one county, the protocol committee shall determine if it shall be established for each county in the judicial circuit or if it will serve all of the counties within the judicial circuit. O.C.G.A. § 19-15-2(b)(3).
[2] O.C.G.A. § 19-15-2(e).

- Identify the steps that must be completed as part of the investigation and prosecution processes, the time frames associated with those steps, and the persons responsible for completion of those steps.
- Strengthen and clarify relationships between child abuse response agencies.
- Inform and educate stakeholders and the community about the response to reports of abuse.
- Ensure that cases are handled in a consistent manner, while recognizing that each individual child and family requires a unique response.
- Provide a concrete and practical plan for addressing special issues that may arise.
- Improve communication, credibility, and accountability of committee members.

HOW DOES THE CAP DIFFER FROM THE MDT, LIPT, AND CFR? The CAP is a comprehensive guide to the handling of all child abuse cases, including sexual abuse and sexual exploitation. The Multi-Disciplinary Team (MDT) is one part of the process that should be incorporated into the CAP; this team is focused on reviewing individual cases of sexual abuse and severe physical abuse to collaborate for appropriate intervention and treatment. The Local Interagency Planning Team (LIPT) is another part of the process that should be incorporated into the CAP as it focuses on ensuring appropriate services are in place for children with mental health and behavioral health needs. The local Child Fatality Review (CFR) supported by the statewide Child Fatality Review housed within the Georgia Bureau of Investigation (GBI) is yet another part of the process that may be incorporated into the CAP as it focuses on reviewing cases where a child has died or suffered a near fatality or serious injury; part of CFR's goal is to understand what led to the incident and what prevention efforts are needed moving forward.

In preparing this protocol, we acknowledge that child abuse exists and that the experience of any such abuse has a negative impact on the child, and, ultimately, society. Each of us, as a signatory agency and as an individual, has a responsibility to respond to allegations of child abuse properly. It is necessary for each of us to be aware of our own biases and prejudices so as to reduce the potential for disproportionality[3] throughout the systems in which we operate. Further, we recognize that no one agency or discipline can address any one instance of child abuse alone, given the significant complexities that are involved. Appropriate responses and interventions are multi-faceted and require each participating agency, with its own body of knowledge, procedures, and mandates, to work with each other to ensure an individualized response for each situation. This protocol can be viewed as a strategy for effective intervention as we seek to mobilize our strengths to better serve child victims and their families. It is our collective and unified desire to minimize the trauma to the child and to prevent further abuse.

The following procedures represent a cooperative effort on the part of the protocol committee members in Clayton County who respond to child abuse. This protocol recognizes that no protocol can purport to offer a comprehensive set of guidelines for the infinite number of circumstances that human service providers face daily. When workers face situations not specifically covered by this Protocol, they are urged to use the protocol in conjunction with agency supervision and their own judgment to provide safety and welfare for the children of Clayton County. The signatories to this protocol are committed to continuing as an interagency committee as required by law and to periodically review and refine this interagency protocol for responding to child abuse. In so doing, the protocol committee will identify critical issues, needs, and resources required to facilitate and enhance the prevention, investigation, and prosecution of child abuse.

[3] See https://www.childwelfare.gov/topics/systemwide/cultural/disproportionality/ for further information on disproportionality in the child welfare system.

II. The Protocol Committee

The chairperson[4] of the Clayton County Child Abuse Protocol Committee is District Attorney Tasha M. Mosley[5]. This committee also consists of the following members designated to represent the following agencies[6]:

1. *Clayton County Sheriff's Office*
2. *Department of Family and Children Services*
3. *Clayton County District Attorney's Office*
4. *Clayton County Solicitor-General's Office*
5. *Clayton County State Court*
6. *Clayton County Juvenile Court*
7. *Clayton County Magistrate Court*
8. *Clayton County Public Schools*
9. *Clayton Center*
10. *Clayton County Police Department*
11. *Forest Park Police Department*
12. *Clayton State University Police Department*
13. *College Park Police Department*
14. *Jonesboro Police Department*
15. *Lake City Police Department*
16. *Lovejoy Police Department*
17. *Morrow Police Department*
18. *Riverdale Police Department*
19. *Clayton County Public Schools Police Department*
20. *Clayton County Fire and Emergency Services*
21. *Department of Juvenile Justice-Martha K. Glaze Regional Youth Detention Center*
22. *Clayton County Board of Health*
23. *Clayton County Medical Examiner's Office*
24. *Court Appointed Special Advocate (CASA)*
25. *Securus House*
26. *Southern Crescent Sexual Assault and Child Advocacy Center*

Consistent with O.C.G.A. § 19-15-2, this committee and the agencies subject to this protocol agree to:

1. Adhere to this protocol;
2. Receive training as necessary and consistent with O.C.G.A. § 19-15-2;

[4] The chairperson is responsible for ensuring that written protocol procedures are followed by all agencies.

[5] O.C.G.A. § 19-15-2(b) requires the chief superior court judge of the circuit in which the county is located to establish the protocol committee and appoint an interim chairperson who presides over the first meeting. The chief superior court judge is also tasked with appointing persons to fill any vacancies on the protocol committee. After the committee is established, the committee members elect a chairperson from the protocol committee's membership.

[6] If any designated agency fails to carry out its duties relating to participation on the protocol committee, the chief superior court judge of the circuit may issue an order requiring the participation of such agency. Failure to comply with such order shall be cause for punishment as for contempt of court. O.C.G.A. § 19-15-2(c)(6). If any member's agency experiences an issue with the operation of the protocol, that member needs to initiate contact with any other agencies involved with the issue and work to resolve the matter. The resolution of the matter should be forwarded as soon as possible to the Chairperson for tracking purposes and inclusion in the next quarterly meeting.

3. Collaborate, coordinate, and cooperate with each other and others[7];
4. Interact respectfully and non-discriminatorily with each other as well as the children, parents, families, and alleged perpetrators with whom they encounter;
5. Respond to cases of alleged child abuse efficiently;
6. Minimize stress created for the child by the legal and investigatory process by being trauma-informed and operating in a trauma-responsive way[8];
7. Ensure that effective treatment, including counseling, is provided for the child, the family, and the perpetrator;
8. Facilitate and support agencies, organizations and individuals whose efforts are directed toward abuse prevention;
9. Be familiar with each person's/agency's responsibilities, including their own, as well as other agency's responsibilities. Recognize how any one person's or agency's role affects other agencies and roles;
10. Consistent with confidentiality and privacy laws, share information with each other;
11. Close the committee's meetings to the public and participate in committee meetings[9];
12. File the protocol with the Office of the Child Advocate and the Georgia Division of Family and Children Services. Meet at least twice annually for the purpose of evaluating the effectiveness of the protocol and modifying and updating the same. File updated protocols with these state agencies by September 1 of each year[10];
13. Issue an annual report[11] no later than July 1 of each year. Transmit this annual report to the county governing authority, the fall-term grand jury of the judicial circuit, the chief superior court judge of the circuit, and the Office of the Child Advocate for the Protection of Children and include the following[12]:
    a. An evaluation of the extent to which investigations of child abuse during the 12 months prior to the report have complied with the protocol;
    b. A recommendation of measures to improve such compliance; and
    c. A description of which measures have been successful in preventing child abuse within the county or circuit. This could include prevention activities such as enhanced primary care; behavioral parent training programs; treatment to lessen harms of abuse exposure; and treatment to prevent problem behavior and later involvement in violence.

III. Child Abuse Prevention[13]

Child abuse is preventable; it is not inevitable. It rests on the principle that all children should have safe, stable, nurturing relationships and environments. Child abuse is not typically caused by a single

[7] In some cases, it will be necessary to work with peers and colleagues from different counties, jurisdictions, and states. These stakeholders should be approached in the same collaborative and cooperative manner.
[8] Each agency subject to this protocol shall ensure that its employees are familiar with adverse childhood experiences (ACEs) and are trained to be trauma responsive. See https://www.childwelfare.gov/topics/responding/trauma/ for information on trauma-informed practice. It may be helpful to reference this self-assessment guide: https://www.nctsn.org/sites/default/files/resources/special-resource/trauma_informed_juvenile_court_sef_assessment.pdf. When operating in a trauma-responsive manner, it is helpful to ask, "What happened to you?" as opposed to, "What is wrong with you?"
[9] In the event a member of the committee fails to adhere to the protocol or is routinely absent from committee meetings, an appropriate course of action should be pursued which may include: 1. Notification/reminder to the offending person(s) of the requirements and proper procedures; 2. Notification to the offending person's immediate supervisor (continuing up the chain of command as necessary) of the failure to adhere to the protocol; 3. If not remedied, a subpoena may be requested to obtain cooperation; or 4. Revisions to the protocol, if any of its non-legally mandated provisions become outdated or are no longer practical. When determining the appropriate course of action, the committee shall bear in mind that the purpose of the protocol is to foster communication and cooperation amongst involved agencies.
[10] O.C.G.A. § 19-15-2.
[11] A sample annual report can be found in Appendix C.
[12] O.C.G.A. § 19-15-2.
[13] See Appendix F for prevention-focused protective factors and examples of prevention efforts.

factor, but rather is influenced by multiple complex factors related to the individual, family, community, and greater society. As such, it requires a public health approach involving the entire community to prevent and treat child abuse. Much progress has been made in understanding how to prevent child abuse and many common informal and everyday actions in addition to formalized evidence-based prevention focused programs all count towards prevention efforts. Fortunately, preventing child abuse can also help prevent other forms of violence and lead to healthier individuals and communities.[14]

Effective prevention involves strategies, programs and connections to resources that support families within their communities. It is enhanced by a multi-disciplinary approach throughout the community that involves coordination, collaboration, and positive working relationships amongst all levels of public and private agencies, individuals, groups, and disciplines involved in prevention and treatment of child abuse. Prevention strategies can be implemented before abuse or trauma occurs or after abuse has occurred to prevent subsequent abuse. Prevention programs may fall under several different categories, including public awareness efforts, parent education and support groups, and community prevention efforts.[15]

The goals of prevention in the CAP include developing and maintaining healthy nurturing communities; identifying the methods that have been implemented to prevent child abuse; tracking statistical information relating to prevention methods and child abuse cases; and utilizing data to determine needed community prevention and treatment services.

Prevention efforts, including primary[16], secondary[17], and tertiary[18] efforts, in place in Clayton County include:

1. Refer to Appendix F[19]

IV. Procedures for Investigating and Prosecuting Child Abuse Cases

4.1 Overview of Roles

Each committee member and the agencies/entities each member represents has an important role to fulfill in the investigation and prosecution of child abuse cases:

1. Mandated reporters, including education personnel and medical personnel among others, are primarily responsible for identifying and reporting suspected child abuse.
2. Law enforcement is primarily responsible for investigating a situation to determine whether a crime has been committed; identifying and apprehending the offender(s); and filing appropriate criminal charges.

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[14] Children who are abused may suffer from the following: immediate physical injuries; emotional and psychological problems; increased risks of injury; sexually transmitted infections; mental health problems; delayed cognitive development; reproductive health problems; and involvement in human trafficking. Research suggests that by stemming the early development of violent behavior, we can also reduce other types of violence to young people, such as youth violence, intimate partner and dating violence, sexual violence, and self-directed violence.

[15] See https://www.childwelfare.gov/topics/preventing/prevention-programs to learn more.

[16] Primary prevention activities support the general well-being of families and children and are directed toward the general public with a focus on preventing maltreatment before it occurs.

[17] Secondary prevention supports families and children at higher risk for incidents of child abuse through early detection and intervention.

[18] Tertiary prevention supports families and children after abuse has already occurred by intervening to prevent a recurrence of abuse and alleviating the effects of trauma and preventing additional trauma.

[19] See Appendix F for examples of prevention efforts. Refer to Georgia's Child Abuse and Neglect Prevention Plan (CANPP) found here: http://strengtheningfamiliesga.net/wp-content/uploads/2020/09/A-Vision-for-Child-and-Family-Wellbeing-in-Georgia-the-states-CANPP2020.pdf for further information on specific prevention efforts that communities may establish. Additional information and resources related to preventing child abuse can be found on Prevent Child Abuse Georgia's website at https://abuse.publichealth.gsu.edu/.

3. DFCS is primarily responsible for responding to reports of abuse to determine if maltreatment occurred; assessing safety and risk; ensuring the safety of the alleged victim and any other children in the home; and ensuring the family has access to appropriate services.
4. Child Advocacy Centers (CACs) are an integral part of the joint investigations between Law Enforcement and DFCS. CAC's are primarily responsible for conducting Forensic Interviews and Forensic Medical Exams to aide in the investigation process conducted by law Enforcement and/or DFCS.
5. Medical personnel, mental health organizations and counselors, child advocacy centers, and sexual assault centers provide exams, diagnoses, and treatment.
6. Coroners and medical examiners evaluate and determine a person's manner and cause of death. Their findings may inform the criminal or civil response to cases involving child abuse.
7. Superior Courts maintain jurisdiction for felony criminal matters related to child abuse. State Courts handle misdemeanor trials (domestic violence cases). Magistrate courts are primarily involved in child abuse cases through the issuance of criminal warrants against perpetrators, the holding of probable cause hearings, and setting bond and/or conditions of bail. District attorneys and the Solicitor's office are responsible for prosecuting criminal actions of child abuse.
8. Juvenile Courts maintains jurisdiction for dependency matters[20] related to child abuse.

IV.2 Communicating with and Interviewing Children

At the time a child makes a disclosure of abuse, or an adult otherwise has a suspicion that the child is being or has been abused, the adult should be careful to gather only enough information to determine if a report is necessary.

Any communication with a child should be respectful, trauma-informed, and responsive, developmentally appropriate, and sensitive to that child's particular needs, culture, and language. When allegations or concerns of abuse exist, the child should be interviewed about these allegations outside of the presence of the parent/caregiver/alleged perpetrator, and only by a trained, appropriate Forensic Interviewer. Give special consideration to the child's safety following a disclosure of abuse, especially if the parents/alleged perpetrator have been informed of the interview or disclosure and whether the alleged perpetrator continues to have access to the child.

When conducting joint investigations, responders will work collaboratively to determine who will take the lead role on interviewing the child. Generally, it will be a Forensic Interviewer through the CAC.[21]

A rapport should be established between the child and the interviewer. Then the interviewer should assess the child's development and level of understanding in a manner consistent with the Child First protocol or another nationally recognized Forensic Interview protocol. The interview should be stopped if the child appears to be too distressed or too uncomfortable.

4.2.1 Children with Special Needs

All agencies are required to adhere to federal laws and regulations related to people with disabilities, specifically, Title II of the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973.[22] Collectively, these laws prohibit public and private entities from discriminating against

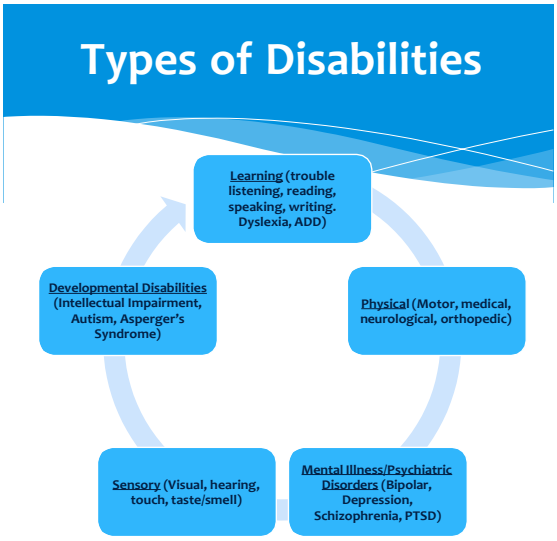
[20] Dependency proceedings may be commenced in the county in which a child legally resides; or in the county in which a child is present when the proceeding is commenced if such child is present without his or her parent, guardian, or legal custodian or the acts underlying the dependency allegation are alleged to have occurred in that county. O.C.G.A. § 15-11-125.

[21] See Section 4.6 for further information regarding forensic interviews and evaluations.

[22] Learn more here: https://www2.ed.gov/about/offices/list/ocr/disabilityoverview.html. Contact OCA for additional resources or training needed as it relates to the intersection of disability requirements and child welfare requirements.

people[23] with disabilities and ensure equal opportunity to participate in and benefit from a wide range of services and programs. These requirements include accommodations for communication and requirements for accessibility to services, which requires "state and local government programs [to] ensure effective communication with individuals with disabilities by providing appropriate auxiliary devices." The requirements include "furnish[ing] auxiliary aids when necessary to ensure effective communication, unless undue burden or fundamental alteration would result." There should also be no discrimination on the basis of a disability by public accommodations.

Everyone that is subject to this protocol agrees to adhere to Title II of the ADA and Section 504 of the Rehabilitation Act throughout the entirety of their involvement with anyone to whom these laws are applicable. Adhering to these laws includes the following:



- Establish rapport and respectful communication with the child. Assume the child is competent unless/until you learn otherwise.
- Determine whether the child has a disability[24]. If so, determine how the child best communicates his or her wants and needs; determine what makes it easiest for the child to understand what others communicate; determine what, if any, accommodations[25] are needed and when they are needed[26]; and provide such accommodations.[27]
- Create a safe and non-judgmental environment.
- Do not ask for a lot of details or rephrase questions as it may cause confusion.
- Do not touch the child as this could cause a fight or flight response in children with certain disabilities.

4.2.2 Interviewing Children at School

- Child abuse-related interviews by DFCS, the district attorney's office, and/or law enforcement may be conducted at the child's school during school hours. In such cases, school staff should assist these agencies by providing a private setting conducive to interviewing children. No school district employee or school-allied volunteer will contact a parent/guardian regarding the interview of their student in child abuse referrals.
- Anyone seeking to conduct an interview with a child at school will endeavor to reduce disruption at the school and for the child.
- When planning to conduct a preliminary or subsequent interview at school, DFCS staff or law enforcement may contact school personnel prior to being on site for the interview.
- Upon arrival to the school, the interviewer should be prepared to sign-in and show proper identification/authorization.
- The school personnel will facilitate arranging the private location and logistics for preliminary or subsequent interviews.

[23] While the focus of this section is on children, these laws pertain to people of all ages. It may be appropriate to also include procedures relevant to interacting with and providing appropriate accommodations to adults with disabilities within this protocol.
[24] This includes physical disabilities as well as cognitive or developmental delays.
[25] This may include adaptive equipment or adjustments to environments or processes.
[26] For instance, someone may require an accommodation related to an interview but not related to accessing the physical location for the interview.
[27] Determining appropriate accommodations will likely involve asking the person with the disability what specific accommodations that person needs.

- A child will not be detained beyond normal school hours nor will the child be transported by DFCS without the permission of the parent or legal guardian or an appropriate court authorization. If a child is removed from school by a DFCS caseworker or law enforcement officer, the child's parent or legal guardian will be notified by either DFCS or law enforcement. If the child's parent/legal guardian contacts the school, that person will be referred to DFCS or the appropriate law enforcement agency.
- School personnel will check in with the child following an interview that takes place at the school to determine whether the child would like some time to process the interview or otherwise receive support from a school counselor.
- If the school is part of the ongoing treatment plan for the child, DFCS will keep the school informed about the subsequent findings and plans for the child and family. The goal is to share information and it will be the responsibility of DFCS to attempt to include the school as part of their treatment plan through case documentation.
- If school is not in session or the child is pre-school age, the DFCS and law enforcement representatives will make a decision as how best to interview the child away from the alleged perpetrator.

4.3 Reports of Child Abuse

WHAT IS CHILD ABUSE? Child abuse is defined as[28]:

- Physical injury or death inflicted upon a child by a parent or caretaker thereof by other than accidental means (provided, however, that physical forms of discipline may be used as long as there is no physical injury to the child).[29]
- Neglect[30] or exploitation of a child by a parent or caretaker thereof.[31]
- Endangering a child,[32] which includes the following acts:

[28] This definition is found in O.C.G.A. § 19-7-5 and is relevant to mandated reporting. Similar and additional definitions of child abuse are included in O.C.G.A. § 15-11-2 and are relevant to legal proceedings conducted in Juvenile Court.
[29] O.C.G.A. § 19-7-5(b)(4)(A).
[30] Depending on the circumstances, truancy may be considered educational neglect and therefore treated as a dependency case or a status offense and therefore treated as a Child in Need of Services (CHINS) case. See O.C.G.A. § 15-11-2(11)(A)(i).
[31] O.C.G.A. § 19-7-5(b)(4)(B). Neglect or exploitation may include "failure to thrive" or Factitious Disorder/Pediatric Condition Falsification/Munchausen Syndrome by Proxy (MSBP) Disorder.
[32] O.C.G.A. § 19-7-5(b)(6.1).

- Cruelty to children in the third degree.[33] This includes a primary aggressor intentionally causing or permitting a child to be present and seeing or hearing a forcible felony, battery, or family violence battery.
- Intentionally causing or permitting a child to be present where any person is manufacturing meth or possessing a chemical substance with the intent to manufacture meth.[34]
- Driving under the influence with a child under the age of 17 years in the car.[35]
- Prenatal abuse.[36]

- Sexual abuse of a child.[37]
  - Includes consensual sex acts when the sex acts are between minors if any individual is less than 14 years of age.
  - Does not include consensual sex acts when the sex acts are between a minor and an adult who is not more than four years older than the minor.
  - This provision of the law shall not be deemed or construed to repeal any law concerning the age or capacity to consent.
- Sexual exploitation.[38]
- Emotional abuse.[39]

Mandated Reporters Include:

- Physicians, licensed to practice medicine, physician assistants, interns, or residents
- Hospital or medical personnel
- Dentists
- Licensed psychologists & interns
- Podiatrists
- Registered professional nurses or licensed practical nurses
- Licensed professional counselors, social workers, or marriage and family therapists
- School teachers, including daycare providers
- School administrators
- School guidance counselors, visiting teachers, school social workers, or school psychologists
- Child welfare agency personnel
- Child [serving] organization personnel (employees and volunteers)
- Law enforcement personnel
- Reproductive health care facility or pregnancy resource center personnel and volunteers

O.C.G.A. § 19-7-5(c)(1)

REPORTING CHILD ABUSE. Reports of child abuse may come from mandated reporters[40] or non-mandated reporters. Mandated reporters[41] are required to make a report to DFCS immediately, but in no case later than 24 hours from the time there is reasonable cause to believe that suspected child abuse has occurred. Some mandated reporters may have the requirement to notify a designated person within their agency who will have the responsibility to notify DFCS of the report on that person's behalf. Mandated reporters will not conduct their own detailed interview but will gather sufficient information to determine if a report is necessary.

Clayton County Law Enforcement

(1) **Law Enforcement will:**

a) Initiate an investigation within 24 hours for children who are indicated to be in present or impending danger and within five days on all other referrals.

b) Determine if the allegation of sexual abuse, physical abuse, emotional abuse or neglect is founded by probable cause, and if the crime occurred in the jurisdiction of the agency.

c) Handle child abuse cases in a priority manner depending on severity of abuse referred.

d) Be familiar with the Clayton County Child Abuse Protocol and make every attempt to follow the protocol.

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[33] O.C.G.A. §§ 19-7-5(b)(6.1)(A) and 16-5-70.
[34] O.C.G.A. §§ 19-7-5(b)(6.1)(B) and 16-5-73.
[35] O.C.G.A. §§ 19-7-5(b)(6.1)(C) and 40-6-391.
[36] O.C.G.A. §§ 19-7-5(b)(6.1)(D) and 15-11-2(56).
[37] O.C.G.A. §§ 19-7-5(b)(10), 19-15-1(3)(C), and 15-11-2(69).
[38] O.C.G.A. §§ 19-7-5(b)(11), 19-15-1(12), and 15-11-2(70).
[39] O.C.G.A. § 15-11-2(30). Although "emotional abuse" is not included in O.C.G.A. 19-7-5 for reporting purposes, it is included in the juvenile code. For reporting purposes, "emotional abuse" may be consistent with "endangering a child" or "neglect".
[40] Most if not all of the protocol committee members are mandated reporters. Mandated reporters and non-mandated reporters alike should be familiar with potential indicators of different forms of child abuse. A listing of these indicators can be found in Appendix G.
[41] Mandated reporter training is available online or in person through Prevent Child Abuse (PCA) Georgia at https://abuse.publichealth.gsu.edu/free-online-mandated-reporting/.

e) Have at least one officer with advanced training in the area of child abuse investigation. This officer should be used as a resource for all the officers in the agency and should assist with the more severe cases of child abuse reported to the agency, if necessary.

f) Ensure that an interview of the child is conducted by a trained interviewer at the Southern Crescent Sexual Assault and Child Advocacy Center.

g) File an intake report with DFCS when a referral of child abuse is received.

h) Notify DFCS immediately if abuse occurred in child's home or caregiver situation.

1. In cases of child-on-child abuse, DFCS should be notified.

(2) **Law Enforcement Staffing Referrals with DFCS**

Early and continued communication between DFCS and Law Enforcement is imperative to avoid separate and parallel investigations.

To optimize this interagency communication, Law Enforcement should consider:

a) Appointing one or more individuals to receive referrals daily from DFCS.

b) Meeting or corresponding with DFCS weekly to staff referrals.

c) Checking their local files and criminal histories of suspects whenever possible prior to making a decision on the disposition of a referral.

d) Notifying DFCS if law enforcement records contain a past history of child abuse, domestic violence or physical assaults involving the child or immediate family members. A joint decision should be made on how Law Enforcement will assist.

e) Inquiring of the DFCS case manager what action was taken by DFCS.

f) In conjunction with the DFCS case manager and supervisor, determine if law enforcement assistance is necessary.

Law Enforcement agrees to work jointly with DFCS in the above situations as well as upon request by DFCS.

Fire & Emergency Services

(1) Pursuant to **OCGA § 19-7-5(d**), reports of child abuse may come from non-mandated reporters.

(2) In incidents deemed to be non-life-threatening reports are to be made to DFCS.

(3) Any first responder shall immediately notify the appropriate local police agency of suspected cases of abuse, pursuant to **OCGA § 19-7-5(e)**. In no case shall the report be made more than 24 hours from the time the responder has reason to believe the child has been abused.

(4) The staff member should not verbally disclose to the parents/guardians or legal custodians of the child that a report is being made until the safety of the child has been established.

(5) Pursuant to **OCGA § 19-7-5(f),** reports of suspected abuse and/or neglect made to appropriate protective services or police agencies in good faith render the reporter immune from civil or criminal liability.

Pursuant OCGA § 19-7-5, Emergency Medical Services personnel shall be considered a mandated reporter as defined as "Medical Personnel". Code Section 16-12-100(B).

****If responding personnel encounters incidents where signs of present or imminent danger, serious bodily injury and/or physical abuse are present, they are to contact the appropriate police authority while on the scene. The responding law enforcement officer(s) will initiate an investigation**.

Medical Personnel

Medical personnel should respond to suspected abuse and neglect cases. It should be

emphasized that according to **OCGA § 19-7-5(e)**, a report should be made to DFCS within 24 hours; however, a timely referral is critical in a multi-disciplinary approach and immediate reporting to DFCS is desirable. Reports are taken 24 hours a day, 7 days a week by calling **1-855-GACHILD/1-855-422-4453**.

(1) **Procedures for Temporary Protective Custody of a Child by a Physician Without a Court Order and Without Parental Consent**

The desired procedure whenever abuse is suspected is to notify DFCS by calling **1-855-GACHILD/1-855-422-4453** or reporting the suspected abuse to Law Enforcement; however, in some circumstances events may evolve too quickly for a physician to pause to contact DFCS or Law Enforcement in order to protect a child who is at risk of 'imminent danger.'

The *elements* necessary for temporary protective custody to be taken by a physician are:

A physician has *reasonable cause* to believe that such child is in a circumstance or condition that presents an **imminent danger** to such child's life or health as a result of suspected abuse or neglect **or** has been abused or neglected and there is **not sufficient time** for a court order to be obtained for temporary custody of such child before such child may be removed from the presence of the physician.

(2) **Physician Liability**

Any hospital or physician acting in good faith and in accordance with accepted medical practice in the treatment of the child shall have immunity from any liability, civil or criminal, that might be incurred or imposed as a result of taking or failing to take any action authorized herein. OCGA § 15-11-131 (h).

Clayton County Health District
1117 Battle Creek Road
Jonesboro, Georgia 30236
(678) 610-7199

(6) The staff member shall immediately orally notify DFCS of suspected cases of abuse, pursuant to **OCGA § 19-7-5(e)**. In no case shall the report be made more than 24 hours from the time the staff member has reason to believe the child has been abused.

(7) The incident as reported or observed shall be documented in the child's medical record.

(8) The child's attending physician shall be notified and advised of the incident.

(9) The report to DFCS shall contain the following information: child's name, address, age, race, parents' names, care provider, children involved, as appropriate, and nature of the allegation. (*See Appendix H,* **DFCS Mandated Reporter Form** *to assist in the written reporting process.*)

(10) A copy of the written report shall be maintained in the child's record.

(11) The child's right to confidentiality should be respected. Information regarding diagnosis, current condition, and prognosis should be shared only as necessary in response to pertinent questions posed by protective services personnel. No release of information is required to make this report.

(12) The staff member should not verbally disclose to the parents/guardians or legal custodians of the child that a report is being made to protective services until the safety of the child has been established.

(13) When a report is made, a therapeutic approach shall always be utilized, presenting protective services as a help for families, not a punishment.

(14) Reports of suspected abuse and/or neglect made to appropriate protective services or police agencies in good faith render the reporter immune from civil or criminal liability.

(15) An incident report should be completed by a public health staff member for each suspected/actual incident of abuse.

Clayton County Public and Private Schools

Clayton County Public Schools
1058 Fifth Avenue
Jonesboro, Georgia 30236
(770) 473-2700

If information exists to cause a staff member to reasonably believe a child is a victim of abuse or neglect, a report should be made to DFCS immediately pursuant to **OCGA § 19-7-5(e)**.

What is reported?

- Any physical injury inflicted upon a child by a parent or caretaker by other than accidental means; acknowledging physical forms of discipline may be used by parents, but without physical injury to the child.
- Physical neglect or exploitation of a child by a parent or caretaker. This included but may not be limited to the lack of proper amount of food, clothing, medical care, guidance, supervision, and other general care.
- Sexual abuse of a child. This includes, but may not be limited to employing, using, persuading, inducing, enticing or coercing any minor, who is not a person's spouse, to engage in any act which involves: sexual intercourse, including genital-genital, oral-genital, anal-genital or oral-anal whether between person of the same or opposite sex; bestiality; masturbation; lewd exhibition of the genitals or pubic area of any person; flagellation or torture by or upon a person who is nude; condition of being fettered, bound, or otherwise physically restrained on the part of a person who is nude; physical contact in an act of apparent sexual stimulation or gratification with any person's clothed or unclothed genitals, pubic area, or buttocks or with a female's clothed or unclothed breasts; defecation or urination for the purpose of sexual stimulation; or penetration of the vagina or rectum by any object except when done as part of a recognized medical procedure.
- Sexual exploitation of a child. This includes but may not be limited to conduct by a parent or caretaker who allows, permits, encourages, or requires that a child engage in prostitution or sexually explicit conduct for the purposes of producing any visual or print medium.
- Emotional/Verbal abuse of a child.
- Report of a parent or caretaker who knows that their child is being "sexually harassed", and who refuses to take action to protect the child from further harassment.

In no case shall the report be postponed more than 24 hours from the time the staff member has reason to believe abuse has occurred.

(1) A classroom teacher or other school staff who suspects abuse or neglect must immediately notify the *appointed designee* that such report was made who shall immediately report to DFCS.

(2) A brief report is to be sent to Student Services and Counseling, Enrollment and Post-Secondary Options Departments by the appointed designee.

(3) No employee shall contact a parent or guardian regarding the interview of

their student in child abuse or child neglect referrals.

(4) DFCS or Law Enforcement will be allowed to conduct a brief, preliminary interview as necessary on school grounds. Every effort will be made to provide a private area for the interview.

Charges Against Teachers Abusing Children.

School staff should NOT conduct their own detailed interview of the child and staff should only question the child enough to determine if a report is necessary. School staff should notify DFCS and Law Enforcement immediately.

When school employees report suspected child abuse, DFCS must write to that employee and acknowledge receipt of the report within 24 hours. Within 5 days of completing an investigation, DFCS must disclose to the counselor, or principal if no counselor, whether or not abuse was substantiated. **OCGA § 49-5-41(a)(5).**

All mandated reporter training of school personnel should include training on indicators of abuse which occurs in the school setting; appropriate reporting methods; and recognizing signs of abuse that occur outside the school setting. DFCS can provide Mandated Reporter training annually. Mandate Reporters can also obtain training on-line at https://www.prosolutionstraining.com/store/product/?tProductVersion_id=10933.10

Clayton County Department of Juvenile Justice (DJJ)

Martha K. Glaze Regional Youth Detention Center
11850 Hastings Bridge Road
Hampton, Georgia 30228
770-473-2100

DJJ Headquarters
3408 Covington Highway
Decatur, Georgia 30032
404-508-6500

When any employee, volunteer or contractor believes or becomes aware of any suspected neglect, physical, emotional, sexual abuse, or sexual exploitation of a child under 18 years old (who resides in Clayton County and whose abuse occurred in Clayton County), that employee, volunteer, or contractor shall follow DJJ Policy on Special Incident and Child Abuse Reporting and Commercial Sexual Exploitation Referrals. The suspected or alleged sexual exploitation shall be referred to Child Advocacy Centers of Georgia (CACGA) at 1-866-END-HTGA (1-866-363-4842) and the appropriate law enforcement agency shall be notified within 24 hours.

Clayton County Behavioral Health Service Providers

Clayton Center – Children, Young Adults & Family

Administrative Office
157 Smith Street
Jonesboro, Georgia 30236
770-478-2280

Children's Service
1396 Southlake Plaza Drive
Morrow, Georgia 30260
770-473-2640

If a child discloses sexual abuse or severe physical abuse during psychotherapy or counseling, the mental health provider should NOT attempt a forensic interview. The provider should not question the child in detail about the alleged abuse or attempt to use anatomically correct dolls for investigative purposes. Rather, the provider should gather the appropriate amount of information needed to complete a DFCS report to include what happened, when it happened, where it happened, how it happened and who did it. The behavioral health provider should reassure the child and explain the process to the child for a possible forensic interview by a third party. Information necessary for the agency's investigation of the abuse or neglect is to be shared.

Staff who receive information concerning child abuse or neglect are to report as follows:

(1) Therapists should report directly to DFCS or Law Enforcement immediately and notify their supervisor. *
(2) Clinicians-in-training, clerical staff and other support staff should report the incident or information directly to supervisory staff, to be reported to DFCS immediately. *
(3) Reports are to be made by phone, with a written follow-up if requested by DFCS, or electronically.

* An immediate response from DFCS is required prior to the child's departure if danger of further abuse and neglect is suspected.

Clayton County District Attorney's Office

9151 Tara Blvd, 4th Floor
Jonesboro, Georgia 30236
770-477-3450

Clayton County Solicitor-General's Office

9151 Tara Blvd, Suite 3SL01
Jonesboro, Georgia 30236
770-477-3380

In all cases involving offenses of child abuse or neglect, the Assistant District Attorney, Assistant Solicitor-General, investigator and/or victim advocate with the Victim Witness Assistance Program handling the case should contact DFCS to inquire whether or not a referral has been made. If no referral was previously made by another agency, then that person is to provide all pertinent information to DFCS so they can open an investigation.

WAYS TO REPORT ABUSE: Reports of suspected child abuse are made via DFCS's Child Protective Services (CPS) Intake Communication Center (CICC)[42] by phone[43], email/fax[44], or an online web form[45].[46] When making a report of suspected child abuse, it is helpful for a reporter to include the following information when known:

- The name(s), address(es) or physical location[47], and age(s) of the child(ren);

- The name(s) of the child(ren)'s parents or caretakers;
- The nature and extent of the allegations of abuse, including any knowledge or evidence of previous allegations of abuse; and
- Any other information, including photographs[48], in establishing the cause of the abuse, protective

[42] More details can be found here: https://dfcs.georgia.gov/services/child-abuse-neglect. A sample mandated reporter form can be found in Appendix H.
[43] The phone number for the CPS Intake Communication Center (CICC) is 1-855-GA-CHILD or 1-855-422-4453.
[44] The email address is cpsintake@dhs.ga.gov. The fax number is 229-317-9663.
[45] To use this option, DFCS requires the reporter to complete the Mandated Reporter Training at www.prosolutionstraining.com. This training is required one time and then the reporter will receive a code to use when making a web-based report.
[46] Reporters should maintain their own records of reports made to DFCS.
[47] If an address is unknown, it would help DFCS to be provided with any information about how to best get in touch with the child and family.
[48] Photographs of a child's injuries to be used as documentation in support of allegations by hospital employees or volunteers, physicians, law enforcement personnel, school officials, or employees or volunteers of legally mandated public or private child protective agencies

capacities of the parents, and the identity of the alleged maltreater(s) or any other information that the reporter believes will be useful.

Mandated reporters will carefully consider whether it is appropriate to disclose to the parents/guardians or legal custodians of the child that a report is being made to protective services, especially given that the report is being made with the child's safety in consideration. DFCS will adhere to legal requirements by not disclosing from whom DFCS received a report.

Mandated reporters will also maintain a child's right to confidentiality and adhere to privacy laws. Information regarding diagnosis, current condition, and prognosis should be shared only as necessary in response to pertinent questions posed by protective services personnel. No release of information is required to make this report.

Upon receipt of a report of child abuse for which DFCS has reasonable cause to believe such report is true or the report contains any allegation or evidence of child abuse, regardless of the intake disposition, DFCS will notify law enforcement or the district attorney, and will also notify military law enforcement and family advocacy programs, when the parent/guardian of the alleged victim child is on active duty in the U.S. armed forces.[49]

Also upon receipt of an allegation of child abuse, the DFCS CPS Intake Communication Center (CICC) will make a determination whether a report contains allegations of maltreatment and assign a response time based on the indication of a safety threat to the child. This determination may result in acceptance for further assessment and intervention, a screen out with a referral for services, or a screen out. If accepted for further assessment and intervention, DFCS may assign it to the investigative track or for supportive family services.[50]

Law enforcement[51], DFCS/the Juvenile Court[52], and physicians (in limited circumstances)[53] have the ability/authority to remove a child. [54]

- **Law Enforcement may take emergency custody of a child under OCGA § 15-11-133.**

- **Steps to Remove a Child from a Home (DFCS):**

(1) DFCS may request the assistance of Law Enforcement which has the authority to take immediate action in taking a child into protective custody for 24 hours without a court order and DFCS will then seek a court order as follows:

(2) Local procedure will determine how DFCS obtains an emergency court order from the Juvenile Court during working hours and after hours through one of three contact methods:

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may be taken without the permission of the child's parent or guardian. Such photographs shall be made available as soon as possible to the child welfare agency providing protective services, the appropriate police authority, and military law enforcement. O.C.G.A. § 19-7-5(e).

[49] O.C.G.A. § 19-7-5.

[50] Refer to DFCS Policy found at https://odis.dhs.ga.gov/General for further information on DFCS's processes for making an intake decision.

[51] Law enforcement may remove a child from his or her home, without the consent of his or her parents, guardian, or legal custodian if a child is in imminent danger of abuse if he or she remains in the home; or a child is a victim of trafficking for labor or sexual servitude under O.C.G.A. § 16-5-46. O.C.G.A. § 15-11-133.

[52] DFCS cannot remove a child without a court order. Local procedure, as outlined in this protocol, will determine the steps DFCS should follow to request a removal order from the Juvenile Court. The Juvenile Court will make a determination as to whether a removal is appropriate and either authorize the removal or deny the request.

[53] See O.C.G.A. § 15-11-131.

[54] Any removal requiring transportation of a child under the age of 8 or 4'9" must be done with an approved child safety seat or booster seat. O.C.G.A. § 40-8-76.

a) the Special Assistant Attorney General ("SAAG") will obtain an emergency order for shelter care signed by a judge, or an authorization for shelter care signed by a Juvenile Court intake officer;
b) the Juvenile Court intake officer, directly; or
c) the judge directly granting DFCS immediate temporary custody until a hearing is convened within 72 hours.

- **Procedures for Temporary Protective Custody of a Child by a Physician Without a Court Order and Without Parental Consent:**

(1) The desired procedure whenever abuse is suspected is to notify DFCS by calling **1-855-GACHILD/1-855-422-4453** or reporting the suspected abuse to Law Enforcement; however, in some circumstances events may evolve too quickly for a physician to pause to contact DFCS or Law Enforcement in order to protect a child who is at risk of 'imminent danger.'

The *elements* necessary for temporary protective custody to be taken by a physician are:

A physician has *reasonable cause* to believe that such child is in a circumstance or condition that presents an **imminent danger** to such child's life or health as a result of suspected abuse or neglect **or** has been abused or neglected and there is **not sufficient time** for a court order to be obtained for temporary custody of such child before such child may be removed from the presence of the physician. **OCGA § 15-11-131.**

(2) **Physician Liability**

Any hospital or physician acting in good faith and in accordance with accepted medical practice in the treatment of the child shall have immunity from any liability, civil or criminal, that might be incurred or imposed as a result of taking or failing to take any action authorized herein. OCGA § 15-11-131 (h).

4.4 Multi-Disciplinary Response

A coordinated, multi-disciplinary response is a critical and vital component to the investigation and prosecution of child abuse cases and involves consistent communication; cross-reporting of allegations; joint investigations and collaborative interviewing; and multi-disciplinary case reviews. The goals of a coordinated response are to ensure an appropriate response to concerns of child abuse; minimize the number of interviews a child undergoes; ensure sensitive treatment of the child victim and their family; preserve the integrity of an investigation that may lead to court involvement; enhance the quality of evidence discovered for civil litigation or criminal prosecution while eliminating duplication of efforts; and provide information essential to family treatment agencies. Early cooperation minimizes the likelihood of conflicts among agencies and different philosophies or mandates and encourages consistent reporting practices.

While law enforcement and DFCS shoulder primary initial responsibility for responding to reports of child abuse, and therefore must work closely together, they cannot do their work well without an incredible number of partners. Each report of child abuse brings with it its own set of circumstances and uniqueness. Each entity has a critical role to serve in the child welfare and protection system and necessarily must refer to their own sets of policies and procedures. However, working as a larger team and relying on each other for consultation helps ensure a child receives the most appropriate response possible. As such, law enforcement, DFCS and their partners and participating disciplines should educate each other on their respective roles, abilities, and limitations when responding to child abuse

cases such that everyone understands the dynamics of victimization, child development, and the civil and criminal justice process as it relates to children.

CONSISTENT COMMUNICATION.

- All committee members agree to maintain regular and ongoing contact and communication with each other for any case of child abuse for which they are involved. In doing so, committee members will ensure others involved are aware of the necessary contacts and contact information throughout the life of the case.

CROSS-REPORTING OF ALLEGATIONS. Any committee member that becomes aware of an allegation of child abuse will make a report consistent with the law and the preceding procedures. Clayton County DFCS and Clayton County law enforcement will notify each other when they have received a report containing an allegation of child abuse and have reasonable cause to believe that the allegation is true.[55] Contact may be made with the reporter(s) to gather additional information and obtain any needed clarity. Notifications and cross-reporting of suspected child abuse and related communications will occur in cases including, but not limited to, the following:

- Sexual abuse involving a child
- Sexual exploitation of a child
- Substance use in the home, including by parents or children
- Family violence, intimate partner violence, or domestic violence
- Physical abuse involving a child
- Severe emotional abuse
- Severe neglect involving a child for which DFCS requests assistance
- Refusal by a family to allow a DFCS worker to see the child victim in any abuse investigation or

- The presence of any serious injury on a child for which the explanation offered is inadequate to explain the injury
- Any referral of abuse indicated by a physician
- Munchausen by proxy/pediatric condition falsification/factitious disorder by proxy[56]
- Any suspicious death of a child
- Cases involving child-on-child abuse

JOINT INVESTIGATIONS AND COLLABORATIVE INTERVIEWING.

All committee members will:

- Be familiar with this protocol and adhere to it unless law dictates otherwise.
- Evaluate each situation case-by-case.

[55] This is necessary regardless of whether either agency will be actively involved on an ongoing basis. In some instances, this notification may need to happen immediately, depending on the severity of the circumstances. If the alleged offense occurred outside of the responding officer's jurisdiction, that officer should advise the complainant and assist with filing a report with the appropriate law enforcement agency.

[56] This is a complex area. A coordinated plan of action is necessary and may involve the following tasks: review all of the child's available medical records; obtain verification of as many items as possible (records of drugs purchased, blood levels on child); seek report of child's condition when parent is absent; if appropriate, video monitoring in hospital with plan in place to intervene if child is found to be in danger from perpetrator's actions; follow up protection plan by DFCS; law enforcement and legal actions as dictated by evidence.

- Interact respectfully with each other and children, parents, alleged perpetrators, and any other person involved in a child abuse case, including colleagues from other jurisdictions.
- Give immediate consideration to the child's safety. If out-of-home placement is necessary for the child's safety, consideration will be given to relatives and fictive kin who may be able and willing to provide appropriate care for the child.[57]
- Document (photos/videos/notes) any potential evidence, such as marks or bruises, as appropriate. Share documented information with other relevant protocol members.

Cross-reporting between DFCS and Law Enforcement is critical.

Law Enforcement is a mandated reporter, as listed above. As to DFCS, once a report of child abuse is made or independently discovered by them, and the report contains any allegation or evidence of child abuse, then they shall immediately notify the appropriate police authority or District Attorney. **OCGA § 19-7- 5(e).**

Specifically, as it relates to law enforcement and DFCS, Clayton County law enforcement and Clayton County DFCS will:

- Initiate investigations in accordance with relevant laws and internal policies. Arrange for medical attention, if necessary. Secure the crime scene, gather evidence, and obtain statements, as appropriate.[58] Law enforcement will receive all physical, biological, drug and gun evidence, including sexual assault kits.
- Law enforcement will accompany DFCS upon a request from DFCS to do so when necessary, for securing parental cooperation, access to the child, or protection of the child.
- Conduct an initial screening/review their records and histories [of suspects] whenever possible prior to making a decision on the disposition of a referral and share information about past histories contained in their records with each other.
- Confer with each other and make a preliminary determination as to whether the allegations are founded, and, if so, whether it is appropriate to pursue it as a criminal and/or civil matter.
- Inform one another and any other relevant involved agency of their respective decisions[59] regarding the disposition of any jointly investigated case.
- Notify, consult and communicate with the district attorney regarding prosecution, when appropriate.
- Make any necessary referrals for appropriate services, including those provided through the Victim Assistance Program.
- Have a representative with advanced cross-training as it relates to child abuse investigations, sexual assault, human trafficking, and severe cases. These representatives will operate as liaisons for each agency and serve as a resource for their colleagues, especially for more severe cases of child abuse reported to the agency.

[57] In many cases, this will require at least a basic assessment by DFCS as to the safety and appropriateness of the out-of-home placement and caregiver(s). In some cases, appropriate placement options may reside out-of-state. Georgia DFCS maintains border agreements with Florida, Alabama, Tennessee, North Carolina, and South Carolina; these border agreements may allow a child to be placed in a home across state lines within a matter of hours. See DFCS Policy 15.8 on https://odis.dhs.ga.gov/General for more information.
[58] When appropriate, a re-enactment doll may be used to conduct a re-enactment with a suspect and/or witness. GBI's Child Fatality Review Unit offers access to re-enactment dolls free of charge and may be contacted by calling 404-270-8715.
[59] Nothing contained in this protocol shall be construed to require law enforcement and DFCS agree on any particular disposition.

- Ensure that an interview of the victim child and other children in the home is conducted by a trained interviewer, in accordance with this protocol.[60]
- Engage other agencies, as necessary.
- Participate in subsequent judicial proceedings, including magistrate court hearings.

Specifically, as it relates to first responders:

- All first responders will share any information learned from their involvement with law enforcement and DFCS. This includes any conversations[61] had or observations[62] made during their involvement.

Specifically, as it relates to school law enforcement (Clayton County Public Schools Police Dept.):

- Prompt response by school resource officer to the school location where the complaint of abuse is being made.
- Upon receipt of an abuse allegation, validate the jurisdiction of occurrence.
- School Resource Officer will notify their immediate supervisor and the appropriate jurisdiction.
- School Resource Officer will generate a case number for an incident report to be completed.
- Incident report will be noted as an agency assist report, if the allegation did not take place on school grounds.
- Ensure that school administration, school counselors and/or school social workers are aware of the allegation.
- Ensure that DFCS is notified from the assigned school counselor and/or social worker.
- School Resource Officer will validate that DFCS has in fact been notified, by receipt of email from the school counselor and/or social worker, also to be noted in the incident report.
- Ensure that questioning of the victim is limited during the preliminary investigation, for scheduling of a forensic interview, to prevent repeated victimization and to ensure proper investigative process.
- When visible physical injury exists, ensure that school nurse staff and local EMS are notified for on scene medical assessment.
- School Resource Officer will ensure to take pictures of any visible, physical evidence, which will be inserted into the incident report.
- School Resource Sergeant will ensure that notification is made to department criminal investigations division for their review.
- School Resource Sergeant will ensure that department Command staff has been made aware of the abuse allegation.
- In the event that DFCS and/or Clayton County Court System authorizes for a change of child custody to take place, school law enforcement will transport to the appropriate emergency receiving facility in conjunction with Form 1013.

Specifically, as it relates to the local child advocacy center:

- The Child Advocacy Center (CAC) will share any information learned from their involvement with Law Enforcement and the Division of Family and Children Services. This includes any disclosures, observation and/or conversations made during their involvement.

[60] Law enforcement and DFCS should ask only basic, non-detailed questions to allow for a more detailed interview by a trained interviewer through the local Child Advocacy Center.
[61] This may include but is not limited to conversations with the alleged child victim, other children present, caregivers on scene or in an ambulance, or other household members, neighbors, bystanders, or witnesses.
[62] This may include but is not limited to appearance/initial response of parents/caregivers on scene and observations around sleep environments even if the reason for involvement is not related to sleep safety.

MULTI-DISCIPLINARY TEAMS AND CASE REVIEW

A multi-disciplinary team (MDT) is a group of professionals representing various disciplines, many of whom are parties to this protocol. The MDT works collaboratively to conduct multi-disciplinary case reviews to thoroughly understand case issues; assure the most effective system response possible by sharing information so as to determine applicable resources and/or additional action necessary on cases; enhance communication between team members; and address problems in service delivery. MDT meetings provide agency members with a forum to discuss complex cases with other professionals, and as a result, enhance both the decision-making and intervention processes.

Upon completion of the forensic interview, the multi-disciplinary team by way of the referring agency and CAC makes recommendations regarding the child's need for medical and mental health treatment. The MDT consists of Law Enforcement, DFCS, the District Attorney's office, Solicitor's office, Child Advocacy Center (CAC), Sexual Assault Center (SAC), mental health and medical professionals, domestic violence shelters when a child is involved, and others who provide a coordinated response designed to increase the effectiveness of investigations while reducing the stress and risk of secondary traumatization to children.

Coordination of MDT Meetings

The CAC, DFCS or other designated agency will coordinate multidisciplinary team (MDT) meetings for the primary purpose of facilitating communication between agencies involved in the investigation and prosecution of child maltreatment and agencies responsible for protecting child victims.

MDT members may request to staff any case they believe can benefit from the collaborative input of the team. Requests can include cases involving children who were not seen for services at the CAC as long as there is an active investigation.

Requests for cases to be staffed by the MDT are accepted from any MDT member and/or appropriate agency. Appropriate referral sources include, but are not limited to, DFCS, Board of Education, Law Enforcement, District Attorney's office, Solicitor's office, the Department of Juvenile Justice, medical and mental health personnel, and the Sexual Assault Center.

A special reconvening of the MDT may be called by the District Attorney's office if circumstances change prior to indictment.

Because the purpose of the MDT staffing is to facilitate the sharing of information between agencies, all individuals from DFCS, Law Enforcement, Prosecution, CAC, SAC, domestic violence shelters when a child is involved, medical, and mental health who are involved with a case being staffed should be present and consistently participate in the MDT meetings.

All agencies will cooperate fully in sharing information with each other concerning the abuse allegation, the child, and any other persons involved in the incident in order to fulfill their respective duties. The agencies will assist each other in making the child available for interviewing, if necessary, to fulfill their duties and will inform each other immediately upon learning of a change of location, address, or phone number of the child.

The following relates to the multi-disciplinary team and case review:

- The agencies will assist each other in ensuring the child is available for interviewing, if necessary, to fulfill their duties and will inform each other immediately upon learning of a change of location, address, or phone number of the child.

- The MDT[63] will be scheduled and coordinated by Southern Crescent Sexual Assault and Child Advocacy Center. This agency will ensure MDT members receive the meeting schedules and agenda. MDT members may request to staff any case they believe can benefit from the collaborative input of the team, including but not limited to sexual abuse, severe physical abuse, and unexplained injuries or injuries with inconsistent explanations.
- All MDT members will review their files and come to the MDT meeting prepared to discuss their agency's involvement with the relevant cases.
- Whenever possible, all agencies will cooperate fully in sharing information with each other concerning the abuse allegation, the child, and any other persons involved in the incident in order to fulfill their respective duties.
- The child's best interest[64] will always be the primary consideration in decision-making.
- At the end of each MDT meeting, any participant will have the opportunity to note any concerns regarding non-compliance with the CAP.[65]

4.5 Special Types of Investigations

4.5.1 Department of Early Care and Learning (DECAL)

The Child Care Services Division of DECAL monitors and licenses childcare programs and investigates complaints of childcare programs, licensing violations and reports of unlicensed childcare operations. Two (2) types of licensed childcare programs include childcare learning centers and family childcare learning homes[66].

In addition to contacting DFCS and law enforcement when a child is harmed in a licensed or unlicensed childcare center or family childcare learning center, also contact DECAL at 404-657-5562 or 404-656-5957.

DECAL investigations include conducting interviews with adults and children and assessing the history of the center to determine whether there is any immediate danger to the children there. Possible consequences could range from providing technical assistance to emergency closure of the center.

4.5.2 Residential Facilities including Child Caring Institutions (CCIs), Youth Detention Centers (YDCs) or Regional Youth Detention Centers (RYDCs), and Psychiatric Residential TreatmentFacilities (PRTFs):

- When an intake report involves a Child Placing Agency (CPA), Child Caring Institution (CCI), Outdoor Child Caring Program, Children's Transitional Care Center, or Maternity Home, contact the Department of Human Services' Office of Residential Child Care (ORCC) at = or 404-657-9651.
- When an intake report involves a Youth Detention Center (YDC) or Regional Youth Detention Center (RYDC), contact the Department of Juvenile Justice (DJJ) at djjombudsman@djj.state.ga.us or (855) 396-2978.
- When an intake report involves a Psychiatric Residential Treatment Facility (PRTF), contact the Healthcare Facility Regulation Division at the Department of Community Health (HFRD/DCH) through the intake fax line at (800) 878-6442 or (404) 657-8935, or by contacting the HFRD/DCH central intake line at 404-232-1717, 404-657-5728, or 404-

[63] The local protocol should include the specific name for the local MDT if such a name exists.
[64] There are many factors that should be taken into account when evaluating a child's best interests. These factors can be found in O.C.G.A. § 15-11-26.
[65] This information may be used to assist with compiling the annual report.
[66] http://www.decal.ga.gov/CCS/rulesandregulations.aspx.

657-5726, or online at https://dch.georgia.gov/divisionsoffices/healthcare-facility-regulation/facility-licensure/hfr-file-complaint.

4.5.3 Allegations of abuse in a school setting

If abuse is alleged against an employee of the school system, DFCS, law enforcement (Clayton County Public Schools Police Department), and the District Attorney's Office will conduct all necessary investigations as to the allegations and any resulting criminal or civil action. The school will consider whether it is appropriate to ensure the employee does not have access to the alleged victim pending the investigation outcome. The Clayton County Public Schools Department of Equity and Compliance will report its findings to the School Superintendent or Board of Education for the school's use in determining appropriate disciplinary action pertaining to employment and/or licensing.

4.6 Forensic Interviews and Evaluations[67]

Southern Crescent Sexual Assault and Child Advocacy Center
2 West Main Street
Hampton, GA 30228
Office: 770/507-7772
intake@scsac.org

A Forensic Interview is a single session, recorded interview designed to elicit a child's unique information when there are concerns of possible abuse, neglect or when the child has witnessed violence against another person. An extended Forensic Interview, sometimes referred to as a forensic evaluation, is a multi-session forensic interview conducted with children who may experience difficulty relaying their information during a single interview session.[68]

Forensic Interviews and evaluations are conducted by specially trained individuals[69] and may result in a child providing a statement about events involving abuse and/or neglect. The goal of the Forensic Interview is to allow the child to describe their experience in their own words in a neutral and supportive environment. A benefit of this process is that it minimizes the number of times the child must provide a narrative of the events throughout the investigative process, thereby minimizing additional trauma incurred by the child and increasing the efficiency of coordinated investigative efforts between DFCS and Law Enforcement.

DFACS and Law Enforcement have committed to the joint investigation of child abuse cases, and to the coordination of the investigation of child physical and/or sexual abuse, and other cases deemed necessary, through a child advocacy center (CAC). Clayton County's designated CAC is Southern Crescent Sexual Assault and Child Advocacy Center (hereinafter CAC or SCSAC-CAC).

[68] See Appendix I for further detailed information about forensic interviews and evaluations.
[69] Forensic interviewers are trained through nationally-recognized trainings which usually consist of an intensive three to five day course in which they learn the necessary skills to conduct an investigative forensic interview of a suspected victim of child abuse. Forensic interviewers must also have a minimum of eight (8) hours of specialized training on an annual basis and meet best practice standards as set forth by Children's Advocacy Centers of Georgia (CACGA). Forensic interviewers maintain knowledge and skills related to a child's development, memory, and suggestibility; children as witnesses; interviewing techniques; use of anatomical dolls; characteristics of abuse; false allegations; criminal codes; effects of childhood trauma and stress; and recantation

Forensic Interviews and evaluations are conducted at SCSAC-CAC. The following procedures are related to Forensic Interviews and evaluationswithin Clayton County Judicial Circuit:

- Referrals for a Forensic Interview may be made by DFCS, Law Enforcement, the District Attorney's Office and the Solicitor-General's Office. Referrals should be sent to intake@scsac.org.
- Upon receipt of a referral, the CAC will schedule an interview time. DFCS and Law enforcement[70] representatives must be present to ensure all relevant information is obtained. If the referring agency is not DFCS or law enforcement, a representative of the referring agency must also attend. If any necessary agency's representative is unable to attend, that agency should obtain all relevant information after the interview.
- The representatives present during the interview will have access to observe the interview from a separate viewing room. Once recording begins, it should not be discontinued until the interview is complete.
- Law enforcement, DFCS, and prosecutors may receive copies of the recorded Forensic Interview. The investigative agency will receive access to the recording through Vidanyx, a cloud-based storage system. If DFCS was unable to attend the Forensic Interview, the Case manager may request the Forensic Interview via the records request form found online at scsac.org. The Forensic Interview and supporting documentation will be sent through Vidanyx.
- The child victim should understand that even though a Forensic Interview has been conducted, he or she may still be asked to testify in court.
- The CAC will coordinate a multi-disciplinary team[71] meeting to further discuss the results of the Forensic Interview and support ongoing collaboration amongst involved agencies.

Making Referrals to the Child Advocacy Center (CAC)

In general, children most appropriate for a forensic interview include children for whom there are concerns regarding the following:

- Physical abuse with injuries,
- Severe negligence,
- Emotional abuse,
- Sexual abuse,
- Sexual exploitation,
- Abduction, and/or
- Witness to any type of violence including, but not limited to, domestic violence, rapes and murders.

[70] This may also include FBI representatives in certain situations.
[71] Refer to Section 4.4 Multi-Disciplinary Response for more information regarding multi-disciplinary team meetings.

Referrals can be made by DFCS, Law Enforcement, the District Attorney's office, Solicitor's Office, the Juvenile and/or Superior Court, and Department of Juvenile Justice and Adult Protective Services. An interview time will be scheduled. Although both DFCS and Law Enforcement should be present to ensure all relevant information is obtained, a representative of the referring agency must attend.

Children who are insufficiently verbal for an interview but who present with medical evidence or sexualized behaviors should be referred for multi-disciplinary review.

Forensic interviews of children 3 to 17, or 18 and over if the child is still in high school, shall be video recorded.

After Hours Forensic Interviews: After hours forensic interviews are on a case-by-case basis. Requests needing immediate response may contact the crisis line (770)477-2177. The CAC representative on call will gather significant information to assess the need, in collaboration with law enforcement and DFCS, for after-hours interviews. Special considerations will consider necessity, productivity of interview for investigative purposes, best practices, and best interest of child.

Forensic Interviews of Special Populations

Sexually Exploited Children

- Although normally best practice suggests that children should have a forensic interview as soon as possible, interviews with children who have been sexually exploited may require an interval of time to assess their readiness to be interviewed.
- More than one forensic interview may be required due to dynamics related to exploitation.
- Victims of exploitation may believe that revealing what has happened to them will result in arrest and detention for prostitution, particularly if interviews are conducted in an interrogative tone.
- Further, many children have a 'love' relationship with their exploiter and fear that the state may incarcerate their 'boyfriends' if they are truthful.
- An additional complication is that sexual exploitation victims are frequently brought into the system as suspects or arrestees and some interviews initially take the tone of interrogation. This may make children reluctant to believe the state is trying to help them.
- Effective information gathering requires that service providers and interviewers work to empower the child and help him or her understand their 'victimization.' Trust should be established over time, and the formal forensic interview needs to occur after this trust has been established.
- Children's Advocacy Centers of Georgia (CACGA), a statewide system of care for victims of sexual exploitation, can facilitate connections with victim advocates, family advocates, and specialized service providers who can assist in preparing the child for a forensic interview.
- Format and dynamics of this type of interview are different than traditional sexual abuse cases, because of the special considerations of victims which include:

    - A history of sexual abuse, physical abuse, neglect and/or domestic violence in the home;
    - Victims not identifying themselves as victims;
    - Victims having a strong distrust of authority;

- Victims fearing for the safety of their families or others due to threats made by their exploiter; and
- Victims rejecting any outreach that is perceived as condescending.

- Additionally, due to the omnipresent nature of Human Trafficking cases, where many victims are trafficked across several jurisdictions, these investigations may involve outside agencies. These multi-jurisdiction operations will often involve a wide range of local, state and federal agencies. To ensure that the best outcome is achieved for juvenile victims in these types of cases, Law Enforcement may need to utilize other Federal, State, or local resources to conduct follow-ups on investigations in multi-jurisdiction CSEC cases.

Adult with Special Needs

CACs may also interview reported victims and witnesses who fall outside of the age ranges described above based on special circumstances that may include young adults disclosing abuse that occurred during childhood, or adults with special needs who may have experienced abuse or exploitation.

If a forensic interview is needed for a child with a cognitive or physical disability or other special need, the protocol should be modified to accommodate the needs of the individual child. Children with learning disabilities should also be accommodated to maximize their ability to communicate effectively.

- All agencies involved in the investigation are required to adhere to federal regulations, specifically, Titles II and III of the Americans with Disabilities Act and the Rehabilitation Act. These requirements include accommodations for communication and requirements for accessibility to services.
- Federal regulations require "state and local government programs ensure effective communication with individuals with disabilities by providing appropriate auxiliary devices."
- The basic core of the forensic interview is communication, and it is likely these individuals already have communication devices they use on a daily basis. The requirements include to "furnish auxiliary aids when necessary to ensure effective communication, unless undue burden or fundamental alteration would result."
- There should also be non-discrimination on the basis of a disability by public accommodations.

Documentation of Forensic Interviews

- The interview should be video recorded.
- The assigned caseworker and law enforcement investigator assigned to the case will have access to observe the interview from a separate viewing room.
- Once recording begins, it should not be discontinued until the interview is completed.
- Copies of recorded forensic interviews will only be given to Law Enforcement, DFCS, or Prosecution or by court order as described in 4.3, B (5), below.

CAC Access to Child Abuse Records OCGA § 49-5-41(a) (7.1)

The CAC which is certified, and which is operated for the purpose of investigation of known or suspected child abuse and treatment of a child or a family which is the subject of reported abuse, shall have access to all records and information relevant to the child's case with few exceptions provided. However, any child advocacy center which is granted access to records concerning reports of child abuse shall be subject to the confidentiality provisions of OCGA § 49-5-40(b) and shall be subject to the penalties imposed by OCGA § 49-5-44 for authorizing or permitting unauthorized access to or use of such records.

CAC Release of Records including the Recorded Forensic Interview

While recorded Forensic Interviews will only be released to DFCS, Law Enforcement and Prosecution, nothing prohibits court-appointed guardians ad litem or CASAs from viewing the recorded forensic interviews upon proper showing of their Appointment Order. Other releases must be done under OCGA § 49-5-41(11) and (g)(3).

Every attempt will be made to notify multi-disciplinary team investigators of a request for the recorded forensic interview and the District Attorney's or Solicitor's Office if a case is under indictment or accusation.

Expanded Forensic Interview

At times, the investigative team may determine that multiple forensic interviews are warranted. When possible, the same appropriately trained forensic interviewer should conduct the expanded interview at the CAC.

Potential reasons to conduct more than one session may include, but are not limited to, the following:

- Decision-making regarding protection of the child cannot be made based upon information obtained during the initial interview;
- An interview could not be completed in one session due to the child's level of engagement and/or participation, developmental and/or cognitive abilities, social, emotional or physical functioning, or another reason information could not be fully or effectively gathered in the single session;
- The child was unable to complete the initial forensic interview and needs additional time due to victimization type (e.g., CSEC victims, long-term victims, poly-victims);
- The child disclosed additional information following the initial forensic interview or indicated reasons he or she could not tell, or due to changes in the situation or circumstances, external evidence or corroboration emerged;
- The child did not disclose abuse during the initial forensic interview but there are concerning factors of possible victimization, such as sexualized behaviors, medical findings, statements of other children and/or adult witnesses, pornography, or access by a known offender; and/or
- The child did not disclose abuse during the initial forensic interview but allegedly disclosed to some other person.

Under some circumstances, multiple forensic sessions may also be planned from the beginning and carried out over two to six sessions (typically, as dictated by the needs of the child) to address and fit a particular child's needs. Such needs may include age, developmental disabilities or other special needs, ability to communicate, being multi-lingual and/or requiring an interpreter, multiple allegations, offenders and/or types of abuse, and for those who have been severely traumatized.

Additional CAC Policies

- Following the conducting of an initial forensic interview, the investigating agencies (e.g., Law Enforcement, DFCS, Prosecution) will refer an alleged child abuse victim for additional forensic interview sessions when deemed necessary, based on the previously mentioned reasons. Additional forensic interview sessions will be scheduled only at the request of child protective services, Law Enforcement, and the District Attorney's or Solicitor's Office.
- Additional forensic interview sessions should be conducted by the same interviewer

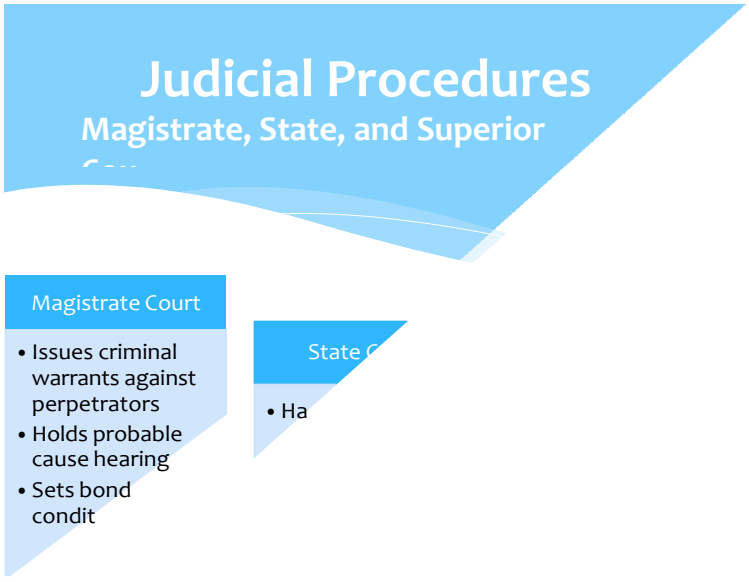
who conducted the initial interview or may be conducted by a different interviewer, depending on the circumstances and needs of the child. All additional forensic interview sessions should be conducted at a certified or accredited CAC in a legally defensible manner that will facilitate protective, therapeutic, and investigative decision-making.

- Non-offending caregivers may accompany the child to the location of the interview but are not allowed to be present or observe additional forensic interview sessions.
- While additional forensic interviews are being scheduled and conducted, it is preferable that the child have no contact with alleged offenders, if identified at the time.
- All involved investigators will provide the forensic interviewer with case information, including the nature and circumstances of the allegations, and any possible alternative explanations for the allegations.
- During the period of time that additional forensic interviews are being conducted with the child, any new information disclosed during the process pertaining to the abuse allegations should be immediately relayed to the involved investigative team members for follow up.

4.7 Prosecution and Court Processes

The court process can be complex and lengthy. Because of the complexities and overlapping processes, it is imperative that committee members and stakeholders communicate regularly and work collaboratively. This section is designed to help stakeholders understand the roles each person/agency plays in the court process and ensure those involved in court proceedings keep the child's best interest at the forefront.

Court intervention does not always result in a removal of a child or a conviction of a crime. Removal is one option of several and these decisions should not be made lightly as the removal of a child from his or her parents can create significant and long-lasting negative impacts on a child. When an investigation of child abuse results in pursuing criminal and/or civil proceedings, the joint investigative efforts will be useful since much of what is learned during the investigative phase is relevant and necessary to the prosecution phase.



The superior court[72], state court[73], and magistrate court[74] in Clayton County are responsible for criminal proceedings related to child abuse. Contact information for the superior court is 9151 Tara Blvd, #1CL25, Jonesboro, GA 30236 (770)477-3395.
Contact information for the state court is 9151 Tara Blvd, Jonesboro, GA 30236 (770)477-3388.
Contact information for the magistrate court is 9151 Tara Blvd, Jonesboro, GA 30236 (770)477-3443.

- The courts will create a trauma-informed and trauma-responsive environment.
- The courts will adhere to all laws, including those related to child testimony, with a focus on minimizing additional trauma to the child when feasible, such that proceedings are conducted in a manner which is protective of the child and absent of perpetrator intimidation, consistent with the defendant's constitutional rights. Note that it is unnecessary for a child abuse victim to appear at a magistrate court probable cause hearing as hearsay is allowed at this hearing.

- The courts will give priority to child abuse cases on the trial calendar, and otherwise schedule cases timely and in accordance with the law, minimizing the number of continuances granted and only grant continuances in accordance with the law and for the shortest time possible.
- The courts will consider all circumstances, paying particular attention to the child's safety when setting bail and bail conditions. The court will consider the potential for further abuse to the child occurring if the accused is released on bond, and the seriousness of the offense in

[72] Superior Court prosecutes felony offenses and hears child custody cases.
[73] State Court prosecutes misdemeanor offenses.
[74] Magistrate Court issues warrants and handles probable cause and bond hearings.

determining the amount of the bond being set. Any conditional bond request should be made by law enforcement at the time the warrant is requested. Restrictive conditions of bond including but not limited to an order to have no contact with the alleged child victim or any other child prior to finalization of the case may be considered. Any and all bond conditions will be communicated to DFCS and the Juvenile Court.

- The courts will ensure that a child who has been abused has a victim advocate to provide support and information throughout the duration of the proceedings. The court and the victim advocate will ensure the victim is familiar with the Crime Victims' Bill of Rights[75] and that all parties adhere to these laws.
- The courts will ensure the child and perpetrator receive appropriate treatment in response to abuse.
- Sentencing will reflect the need to protect the victim from the perpetrator.

The district attorney's office will prosecute criminal cases of child abuse. Contact information for the district attorney is 9151 Tara Blvd, 4th Floor, Jonesboro, GA 30236 (770)477-3450.

- The district attorney and staff will coordinate with law enforcement and DFCS during the course of the investigation and preparing a case for criminal prosecution, including offering advice as to the preparation and execution of search warrants, logistics, and substance of suspect and witness interviews. The district attorney will communicate with others to further support and ensure a well-organized investigation.
- The district attorney and staff will be trauma-informed and trauma-responsive.
- The district attorney and staff will ensure the victim is appointed a victim advocate and receives any necessary and appropriate services through the victim advocate program.
- The district attorney and victim advocate will provide or facilitate a courtroom orientation with a child victim prior to that child being called to testify at trial.
- The district attorney and staff will strive to limit the child's court appearances and need to testify; however, it cannot always be prevented. Regardless, the district attorney and staff will keep the child's emotional well-being a high priority issue throughout the entire process. In the event it is necessary for the child to testify at trial, the district attorney will ensure any necessary and appropriate accommodations or arrangements are in place to minimize the potential trauma to the child.
- The district attorney and staff will discuss any plans for disposition, whether by trial or plea negotiations, with the victim's guardian and/or the victim prior to disposition. The input of the victim and/or the victim's guardian will be noted in the file and taken into consideration during the decision-making process.
- The district attorney and staff will notify DFCS and the SAAG of all case dispositions.

The Juvenile Court in Clayton County is responsible for civil proceedings related to dependency[76], delinquency[77], and Children in Need of Services (CHINS)[78] cases and has the ability to authorize a child's removal from his or her parents. Contact information for the Juvenile Court Intake Operations is 770-473-5977 or juvenile.intake@claytoncountyga.gov (Monday-Friday 8:00 am to 5:00 pm). For afterhours contact, utilize the On Call monthly rotation calendar which is distributed to all local law enforcement agencies and DFCS.

- The Juvenile Court will create a trauma-informed and trauma-responsive environment.

[75] O.C.G.A. § 17-17-1 et al.
[76] Dependency actions pertain to children who have been alleged to be abused.
[77] Delinquency actions pertain to children who have been alleged of committing a crime.
[78] CHINS actions pertain to children who have been alleged of committing a status offense, such as being unruly, truant, or running away. CHINS cases focus on whether a child is in need of care, guidance, counseling, treatment, rehabilitation or supervision relating to the status offense.

- The Juvenile Court will consistently consider and evaluate the child's best interest in accordance with O.C.G.A. § 15-11-26[79].
- The Juvenile Court will adhere to laws related to child testimony, with a focus on minimizing additional trauma to the child when feasible.
- The Juvenile Court will schedule cases timely and in accordance with the law, minimizing the number of continuances granted and only grant continuances in accordance with the law[80] and for the shortest time possible. The Juvenile Court will take into account the child's daily routine and schedule hearings at times that will be as minimally disruptive to the child as possible; this will require consulting with the child and/or child's caregiver to determine what schedule works best for the child.
- The Juvenile Court will ensure the child is appointed an attorney and guardian ad litem at the earliest possible stage and throughout the duration of the dependency proceedings.
- The Juvenile Court will consider the use of protective orders and temporary alternatives to foster care when appropriate in an effort to minimize trauma to the child.[81]
- The Juvenile Court will ensure the child and family receive appropriate treatment in response to child abuse.

Clayton County DFCS is responsible for responding to and investigating reports of child abuse. Contact information for Clayton County DFCS is (770) 473-2323, (770) 603-4600 or Centralized Intake 1-855-Ga CHILD. When DFCS petitions the Juvenile Court for custody of a child, DFCS, represented by their attorney (referred to as a Special Assistant Attorney General (SAAG)), will "prosecute" civil cases of abuse in Juvenile Court. The SAAG(s) for Clayton County DFCS are Toni McDowell (attytgm1@gmail.com) and Lauraill Williams (lauraillw@gmail.com).

- DFCS and the SAAG(s) will be trauma-informed and trauma-responsive.
- DFCS and the SAAG(s) will provide advance notice to witnesses who will be asked to testify during dependency proceedings.
- DFCS and the SAAG(s) will notify the District Attorney's office of all related judicial proceedings involving the child victim.
- DFCS and the SAAG(s) will communicate and collaborate with protocol members to connect families to the appropriate agencies to receive services to address their safety, permanency, and well-being needs to ultimately achieve the best outcome for children and families.

Other protocol committee members involved in a case of child abuse will remain willing and available to participate in criminal and/or civil court proceedings, as necessary.

4.8 Additional Investigation and Prosecution Procedures by Topic

4.8.1 Family Violence (FV)[82]

In addition to standard procedures, make every reasonable effort to:

- Determine whether children are or were present at the residence and obtain their name, age, demeanor, relationship to the parties and whether the child(ren) witnessed, heard, or were physically harmed during the incident (intentionally or accidentally).
- Ask the parties where the child(ren) is/are and observe/interact with the child(ren).

[79] Refer to Appendix B for the best interest factors.
[80] Refer to O.C.G.A. § 15-11-110 for specifics about continuances in dependency proceedings.
[81] This may also include placing a child in the home of an appropriate relative or fictive kin pursuant to an Interstate Compact on the Placement of Children (ICPC) Border Agreement. See DFCS Policy 15.8 on https://odis.dhs.ga.gov/General for more information.
[82] Also referred to as Intimate Partner Violence (IPV) or Domestic Violence (DV).

- If the parties will not or are unable to answer as to the child(ren)'s welfare, and the officer has reason to believe a child(ren) is present by evidence of toys, clothes, etc. or other reason, follow law enforcement protocol for further search of the house.
- If the child(ren) are found at the house, determine whether to seek protective custody and if so, contact the DFCS on-call case worker or director and make a report to DFCS' CPS Intake Communication Center (CICC) so that DFCS can conduct a safety assessment.
- Make a referral or give the adult victim information on the nearest domestic violence shelter and otherwise discuss available services for him/her/their and the child(ren) if needed.
- Include the name of the child and date of birth in the incident reports.
- Try to separate children from the situation and where possible, avoid interviewing parties in the presence of the child or subduing or arresting someone in the child's presence.
- Consider a forensic interview of the child.

Tips for talking with children at the scene:

- Address the child at eye level
- Explain your role in easy-to-understand terms
- Honor a child's loyalty to an abusive parent
- Do not criticize or demean an abusive parent
- Acknowledge the child's right not to speak
- Communicate your concern about the child's safety
- Don't make promises you can't keep
- Discuss confidentiality and its limits

Source: Vermont's 2004 Model Protocol as adapted from a handout developed by the Child Witness to Violence Project, Boston Medical Center (as contained in the 2015 Bryan/McIntosh County Protocol)

4.8.2 Physical Abuse[83]

In addition to standard procedures, the following is relevant when physical abuse is present:

- Obtain medical treatment when needed.
- If medical treatment has previously been sought, obtain medical records, and communicate with the medical provider(s).
- If there is a concern that a child's injuries may have been sustained through non-accidental means, consult a medical provider who specializes in child abuse to obtain an expert medical opinion.[84]
- If a medical provider suspects the child's injuries are consistent with non-accidental trauma, ensure you understand and document their concerns and obtain medical explanations to clarify whether any alternative explanations as to how the child's injuries were sustained are consistent or inconsistent with the medical provider's examination of the child.

4.8.3 Sexual Abuse[85]

Children who may be victims of sexual abuse need to be assessed for their safety, taking into account the physical and/or psychological indications that may exist.[86] Instances of sexual interaction between children should be reported to determine whether sexual abuse existed as part of the interaction and to determine whether either child has otherwise been a victim of sexual abuse to provide appropriate intervention.

- Law enforcement and DFCS will notify each other as soon as they are made aware of a potential victim of sexual abuse. If there is any suspicion that a child who has been sexually abused is also a victim of human trafficking, make a referral to the Children's Advocacy

[83] ~~O.C.G.A. §§ 19-7-5(b)(4)(A) and 15-~~11-2(2)(A).
[84] Children's Healthcare of Atlanta (CHOA) is available for such consultation; contact CHOA at 404-785-7778 for additional information.
[85] O.C.G.A. §§ 19-15-1(3)(C) and 15-11-2(69).
[86] A victim-centered approach should be utilized during this process wherein the child has a say in whether or not they have an exam.

Centers of Georgia (CACGA)[87] for further assessment and see the next section related to sexual exploitation.

- Law enforcement will properly gather evidence from various sources during its investigation.
- The forensic medical and/or sexual assault medical forensic examination shall be conducted at SCSAC-CAC or Children's Hospitals of Atlanta (CHOA) if determined that SCSAC-CAC is not available to render services.
- Forensic Medical Examinations (FMEs) should be offered in ALL cases of sexual abuse, regardless of the length of time that may have elapsed between the most-recently reported sexual contact and the examination. Clinical providers will contact Children's Healthcare of Atlanta (CHOA) [88] at 404-785-7778 if a consultation is needed.
- Forensic Medical Examinations (FMEs) and sexual assault examinations can help to: 1) screen for injuries and medical conditions and initiate medical treatment; and 2) answer questions and reassure victims and parents about the child's physical well-being; and 3) identify medical evidence to prosecute the offender(s).
    - Forensic Medical Examinations[89] and sexual assault exams will be conducted using a trauma-informed, culturally sensitive, rights-based approach by[90] Clayton County.
    - Payment for these exams is available and supported through the Georgia Criminal Justice Coordinating Council (CJCC); victims should not be asked for payment.
    - Victim advocacy services[91] during the exam process will be offered by SCSAC-CAC.
    - The evidence collection kit will be sent to the GBI Crime Lab by the law enforcement agency or district attorney investigator investigating the case.[92]
    - A debrief with the doctor, nurse, or SANE who conducted the exam is an integral part of the investigation.

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[87] Referrals to CACGA for victims of human trafficking can be made via phone at 1-866-END-HTGA (842-4842), HIPAA-compliant web form at https://www.cacga.org/referral-form/ or email at referrals@cacga.org.

[88] CHOA's Stephanie V. Blank Center for Safe and Healthy Children offers multiple ways for community providers and partners to receive assistance with medical exams for suspected victims of abuse. The DFCS medical network allows for providers to receive second opinions from CHOA medical providers; contact CHOA at 404-785-7429 for additional information. There are monthly ECHO sessions where community providers present cases and there is a didactic lecture on relevant topics; contact CHOA at 404-785-6804 for additional information. CHOA also offers trainings; contact CHOA at 404-785-5004 or cpctraining@choa.org for additional information.

[89] These may be conducted through the local Child Advocacy Center (CAC) or Sexual Assault Center (SAC) that has a Sexual Assault Nurse Examiner (SANE) and a Sexual Assault Victim Advocate (SAVA). Some CACs also have an on-site medical examination room. Children's Healthcare of Atlanta (CHOA) conducts these exams. Hospital emergency rooms are able to conduct medical evaluations for the health of the child. Some hospitals may have a pediatric SANE who can conduct the sexual assault examination. If the child is taken to the Receiving Hope Center (RHC), this exam may be conducted there.

[90] While the physician, nurse practitioner, or physician assistant providing care for the child can conduct the medical evaluation, it is preferable for the forensic evaluation to be performed by a provider with expertise in child maltreatment. Experts include child abuse physicians, or other physicians, nurse practitioners or physician assistants with specialized training and experience in child abuse, Sexual Assault Nurse Examiners (SANEs), Sexual Assault Forensic Examiner (SAFEs), or Sexual Assault Medical Forensic Examiners (SAMFEs). SANEs receive specialized training in conducting exams with adults, adolescents and/or pediatrics. SANEs should have physician oversight as they cannot render a diagnosis. Medical professionals are encouraged to seek help from experts when possible by referring the patient for specialized care, by requesting phone consultation, and/or by obtaining a second opinion review of exam photos. A second opinion is especially critical if an inexperienced provider reports positive findings upon exam. For names of local experts, providers should contact the nearest CAC, SAC, CHOA (404-785-3833) or CACGA (770-319-6888).

[91] The National Protocol for Sexual Assault Medical Forensic Examinations – Pediatric recommends the provision of timely access to victim advocacy services during the exam process. Victim advocates typically function to aid victims and their families in getting help to cope with the impact of sexual abuse in their lives and to promote healing. Advocates also encourage coordination and collaboration among responders so that interventions are child-focused and trauma-informed.

[92] Victims of sexual assault may come to a hospital located outside of their county or state of residence or outside of the jurisdiction where the assault took place. The law enforcement agency in the jurisdiction where the assault occurred is the law enforcement agency charged with investigating the assault and facilitating transfer of the evidence collected from the hospital to the appropriate forensic lab in the jurisdiction where the assault took place.

4.8.4 Sexual Exploitation[93]

Children who may be victims of sexual exploitation or human trafficking need to be assessed for their safety, taking into account the physical and/or psychological indications that may exist. In addition to standard procedures and the procedures related to sexual abuse, the following also apply in situationsof sexual exploitation or human trafficking:

- All protocol members should familiarize themselves with the following:
  - Indicators/risk factors of sexual exploitation[94]
  - Georgia's Human Trafficking Notice[95]
  - Georgia's Human Trafficking Service Delivery Plan
  - Georgia's Human Trafficking Service Delivery Protocol
  - DFCS policies related to commercial sexual exploitation of children (CSEC) and trafficking, as well as DFCS' Human Trafficking Case Management Statewide Protocol
  - DJJ policies related to commercial sexual exploitation referrals[96]
  - CACGA's contact information to refer suspected victims of human trafficking[97]
  - GBI's HEAT unit
  - The Human Trafficking Unit within the Georgia Attorney General's office
  - The FBI Violent Crimes Against Children/ Human Trafficking Program - Metro Atlanta Child Exploitation (MATCH) Task Force

If known, the following information will be helpful to provide to CACGA as part of the human trafficking referral:

- Youth information, including whether the youth is pregnant, parenting, or has a disability
- Family/household information
- Medical history
- Mental health, juvenile justice, or child welfare involvement
- Legal custodian(s) of youth and their information
- Reason for the referral along with any known prior history of exploitation, running away, homelessness, substance use, sexual abuse, or gang involvement
- Assessment scheduling preferences
- Whether a CANS assessment has previously been completed
- Copies of screening tools previously used or any other supporting documents
- Consent form and release of information

- Law enforcement and DFCS will notify each other as soon as they are made aware of a potential victim of sexual exploitation or trafficking. Notification should also be provided to GBI's Child Exploitation and Computer Crimes Unit.[98]
- Refer individuals who are suspected to be victims of human trafficking to the CSEC Response Team of Children's Advocacy Centers of Georgia (CACGA)[99]. The CSEC Response Team of CACGA will conduct a comprehensive assessment to include but will not be limited to: the CSE-IT, a Forensic Interview[100], and a bio-psycho-social evaluation.[101] Confirmation status will be provided and when appropriate, recommendations will be made to refer a child for additional evaluations and services[102].

[93] O.C.G.A. §§ 19-15-1(12) and 15-11-2(70).

[94] See Appendix G.

[95] This is required by O.C.G.A. § 16-5-47. The notice is available through GBI; see https://gbi.georgia.gov/human-trafficking-notice. Protocol committees should ensure this notice is in the required places throughout the county/circuit.

[96] https://djj.georgia.gov/commercial-sexual-exploitation-children.

[97] Referrals to CACGA for victims of human trafficking can be made via phone at 1-866-END-HTGA (842-4842), HIPAA-compliant web form at https://www.cacga.org/referral-form/ or email at referrals@cacga.org.

[98] During regular business work days, this notice should be provided to the unit's agent on call via 404-270-8870. On nights, weekends, and holidays, this notice should be provided to the unit's agent on call by calling the GBI communications center at 404-244-2600 or 1-800-282-8746. For further information: https://investigative-gbi.georgia.gov/investigative-offices-and-services/specialized-units/child-exploitation-and-computer-crimes-unit.

[99] Referrals to CACGA for victims of human trafficking can be made via phone at 1-866-END-HTGA (842-4842), HIPAA-compliant web form at https://www.cacga.org/referral-form/ or email at referrals@cacga.org.

[100] If a child is denying victimization, and/or is not cooperative, it may be better to delay the forensic interview until some trust has been established with the child.

[101] The assessment may also include a medical evaluation or mental health assessment.

[102] Therapy is an integral part of treatment for many children who have been sexually exploited. Therapists must be knowledgeable about trauma and skilled in the delivery of trauma-focused treatment in addition to being well-informed about sexual exploitation.

- A request by law enforcement for DFCS or others not to make contact with the child's parents for the safety of the child should be respected. Revealing confidential law enforcement investigatory information to potential suspects could easily place that child that has been recovered or other children that have yet to be recovered in danger. The Juvenile Court should be fully advised of this request when applying for a Shelter Care Order.
- Law enforcement will properly gather evidence[103] from various sources in the course of its investigation.[104]
- The statewide CSEC multi-disciplinary team, led by Children's Healthcare of Atlanta (CHOA) and CACGA's CSEC Response Team, will be available to provide assistance as needed.
- A Forensic Interview will be conducted consistent with the procedures previously outlined in the "Forensic Interview" section. The process for Forensic Interviews for children who have been sexually exploited may differ slightly from traditional Forensic Interviews. Effective information gathering requires that service providers and interviewers work to empower the child and help him or her understand their victimization. Trust should be established over time, and the formal forensic interview needs to occur after this trust has been established.
- If it is necessary for DFCS to seek custody of a child who has been sexually exploited or is otherwise a victim of human trafficking[105], DFCS will adhere to internal policies and procedures related to such victims, including ensuring a current photo of the child is on file, and also refer such victim to CACGA for assessment and further response/treatment if such a referral has not already been made.[106]
- Even if a child is not in DFCS custody, a child may be referred to the CSEC Response Team and Receiving Hope Center for further assessment and short-term placement.[107]

4.8.5 Substance Use

Prenatal substance use. The state[108] is required to develop a Plan of Safe Care (POSC) for families with infants identified as being affected by substance use, or withdrawal symptoms resulting from prenatal drug exposure or a Fetal Alcohol Spectrum Disorder (FASD). A POSC can be implemented with or without DFCS involvement at the outset or on an ongoing basis. The Plan of Safe Care is a process that involves multi-agency partnership with families to develop a written plan that ensures the safety and well-being of infants following release from the care of healthcare providers and addresses the health and substance use treatment needs of the infant and parent/caregiver and the needs of the

[103] Evidence may include, but is not limited to, the following: electronic devices, numbers, and records; online ads, screenshots of applicable internet sites, usernames and passwords for accounts, or other electronic activity; photographs of victim and scene where victim was located; photographs of victim's tattoos and what they mean to victim; relevant security video; hotel workers' statements and hotel records, if applicable; 'exploitation clothing' worn by the victim; anything bought for the victim by the accused person; sheets, blankets, and condoms; fake or stolen IDs along with statements from ID victims; and anything that can corroborate the victim's statement, potentially including a receipt, journal, diary, calendar, or agenda.

[104] It may be necessary to put a cell phone in airplane mode or in a faraday bag to prevent the cell phone from being remotely wiped. It may also be necessary for law enforcement to submit a preservation letter to social media sites.

[105] Traffickers fit the definitions of a "caregiver" or "person responsible for the care of a child" found in O.C.G.A. § 15-11-2.

[106] DFCS' State Office Care Coordination Treatment Unit (CCTU), formerly known as the Placement Resources Operations (PRO) Unit may serve as a support for county DFCS offices to assist with finding an appropriate placement for a child in DFCS custody.

[107] Referrals to the Receiving Hope Center (RHC) may be coordinated through CACGA or directly to RHC via email at RHCreferrals@wellspringliving.org or phone at 470-467-3669.

[108] This is a federal requirement through the Child Abuse Prevention and Treatment Act (CAPTA) for the state as a whole and is not necessarily a requirement for DFCS specifically. However, DFCS maintains policies related to plans of safe care (see DFCS Policy 19.27 available through https://odis.dhs.ga.gov/General) and is typically well-situated to coordinate and partner with other agencies to develop, implement, and monitor this plan. Even when DFCS is not involved, this Plan of Safe Care is still required and this protocol should include procedures for determining which agency will maintain responsibility for monitoring the Plan of Safe Care. (Responsibility may change from family to family and be assigned as the need arises during a Plan of Safe Care meeting.)

other family members affected by the substance use. The Plan of Safe Care will be monitored to ensure referrals are made and appropriate services are delivered to the affected infant, family, or caregiver.[109]

When encountering prenatal substance use and developing a Plan of Safe Care, the following information contributes to a comprehensive plan and should be shared amongst all those responding to and intervening in such situations:

- Current medical condition of the infant and mother;
- Written detail regarding substance(s) used (includes prescribed or non-prescribed substances);
- Level of substance in the mother and/or child's system and whether the mother was receiving medication-assisted treatment (MAT) for a substance use disorder;
- Impact of the substance on the infant, including descriptions of withdrawal symptoms;
- Anticipated date of discharge; and
- Necessary medical follow-up that will be required for the care of the infant (e.g. heart or apnea monitors).

When allegations of prenatal abuse[110] exist, DFCS will need to interview the parent and observe the infant; determine the level of extended family support which might reduce risk to the child; assess the mother's acceptance and responsibility for the situation and her willingness to accept treatment for substance use related problems; refer the mother, child, and family to appropriate prevention or intervention providers; and seek court intervention when necessary.

Postnatal substance use. A parent's substance use on its own does not constitute child abuse; there must be a correlation between the parent's substance use and its interference with the parent's ability to appropriately care for the child(ren). To this end, evidence of substance use and the impact on the child(ren) will be necessary for related court proceedings. In the event that court intervention is sought, stakeholders should consider whether it is appropriate for the parent to participate in family dependency treatment court.[111]

[109] When customizing this protocol, ensure that procedures for determining which agency will take responsibility for monitoring the POSC are included.

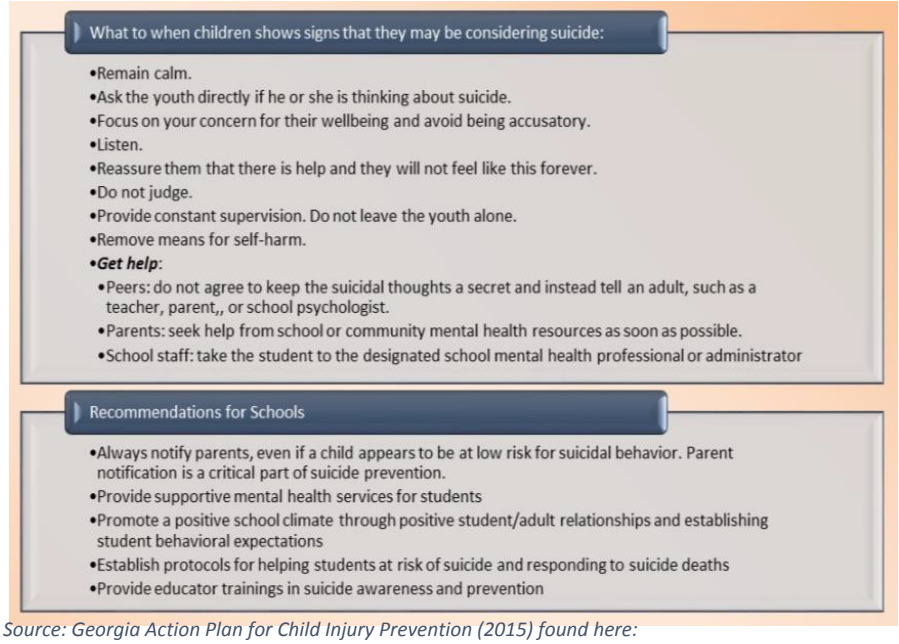
[110] Prenatal substance use may constitute "prenatal abuse" as defined in O.C.G.A. § 15-11-2(56): "exposure to chronic or severe use of alcohol or the unlawful use of any controlled substance…which results in: (A) Symptoms of withdrawal in a newborn or the presence of a controlled substance or a metabolite thereof in a newborn's body, blood, urine, or meconium that is not the result of medical treatment; or (B) Medically diagnosed and harmful effects in a newborn's physical appearance or functioning."

[111] Family dependency treatment court is a type of accountability court that has realized significant success in helping parents with substance use concerns and should be considered a viable option when the jurisdiction has such an accountability court in existence. If your jurisdiction does not have such an accountability court in existence, consider establishing one. Learn more here: https://cacj.georgia.gov/.

4.8.6 Mental Health[112]

Mental health needs may be applicable to children or adults. Children should not enter foster care solely to receive mental health or behavioral health services. Instead, protocol committee members will work together, and in conjunction with the local interagency planning team (LIPT) as necessary, to support access to appropriate services and resources in an effort to maintain a child in his or her home when it is otherwise safe to do so. In addition to standard procedures, the following also apply when mental health concerns are present:

- Mental health needs of a child or an adult may constitute a disability under Title II of the ADA and Section 504 of the Rehabilitation Act of 1973. Ensure all responses are consistent with these laws.[113]
- Contact the Georgia Crisis and Access Line (GCAL) when necessary. For immediate access to routine or crisis services, call 1-800-715-4225.[114]
- Ensure all protocol committee agencies are educated about suicide prevention. Suicide prevention, intervention and aftercare education, information, resources, and PSAs are available through Georgia's Department of Behavioral Health and Developmental Disabilities (DBHDD)[115], the Georgia Suicide Prevention Action Network (SPAN-GA)[116], and the Georgia Bureau of Investigation's Child Fatality Review.[117]



Source: Georgia Action Plan for Child Injury Prevention (2015) found here: https://gbi.georgia.gov/document/publication/georgia-action-plan-child-injury-preventionpdf/download

4.8.7 Child Death, Near Fatalities, and Serious Injuries

When a child dies, suffers a near fatality, or serious injury, the following needs to occur:

- All first responders will gather information that may be pertinent to the incident. This information will be provided to law enforcement and DFCS to inform the investigation and further response to these incidents. Appropriate information includes but is not limited to: the circumstances surrounding the incident; the protective capacity of the caregiver; the condition of the caregiver at the time of the incident; possible contributing factors to the incident, such

[112] All protocol committee members should consider becoming trained in Youth Mental Health First Aid to learn how to help a child who is experiencing a mental health or addiction challenge or is in crisis. Learn more here: https://www.mentalhealthfirstaid.org/population-focused-modules/youth/.
[113] Refer to Section 4.2.1 "Children with Special Needs" for further information.
[114] GCAL is available 24 hours a day, 7 days a week and 365 days a year to help you or someone you care for in a crisis. GCAL professionals will: provide telephonic crisis intervention services; dispatch mobile crisis teams; assist individuals in finding an open crisis or detox bed across the state; link individuals with urgent appointment services; and help you access a local state funded provider for non-emergencies.
[115] https://dbhdd.georgia.gov/bh-prevention/suicide-prevention
[116] https://www.span-ga.org/
[117] https://gbi.georgia.gov/CFR

as substance use, smoking, and/or medical history of the child; and the sleep environment of the child if the incident was sleep-related.[118]

- Notification to other protocol members as appropriate to further coordinate investigation efforts, i.e. to DECAL if the child's death, near fatality, or serious injury occurred in a child care program.
- Engagement with relevant collaterals to obtain or verify information as appropriate.
- A re-enactment of the incident, using a re-enactment doll with the suspect and/or witness(es). Any re-enactment should be video recorded, if possible.
- Coordination with the Coroner or Medical Examiner's Office to arrange an autopsy of the child, when warranted. All pertinent information needs to be shared with the Coroner or Medical Examiner's Office. When and if available, law enforcement should attend the autopsy and obtain photographs from the autopsy.
- Law enforcement needs to obtain crime lab reports (e.g., autopsy, toxicology, blood alcohol, etc.) and share this information as appropriate.
- All agencies should complete any relevant forms related to internal or external procedures related to child death, near fatalities, and serious injuries.
- The incident will be reviewed as part of the local Child Fatality Review[119].
- This protocol committee will work with the Clayton County Child Fatality Review to identify trends and implement prevention efforts[120].
- See Appendix O – Clayton County Child Abuse Protocol[121]

V. Methods to be used in coordinating treatment programs[122] for the child, the family, and the perpetrator

The goal of treatment is to facilitate healing. Therapy[123] can help children (and parents):

- Learn about trauma and child sexual abuse as well as healthy sexuality
- Develop effective coping and body safety skills
- Overcome problematic thoughts, feelings, and behaviors
- Therapeutically process traumatic memories

Providing therapeutic interventions for children who have been abused requires: 1) an understanding of normal child development and the processes of abnormal development or psychopathology as well as an ability to assess the severity and types of behavioral, emotional, developmental, and psychological problems that children who have been abused may present; 2) familiarity with the major issues common to children who have been abused; and 3) the skills necessary to manage these types of cases. Providing treatment to children who have been abused is a significant undertaking requiring clinical training and education.

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[118] In this section, it may be appropriate for local protocols to identify and incorporate information regarding which agency specific first responders will provide information to. It may also be appropriate to include additional specific information that law enforcement, DFCS, or other protocol members may find necessary and helpful.

[119] It may be helpful to identify a local contact person to ensure they are made aware of the need to review a case as part of the local Child Fatality Review (CFR).

[120] Statewide, sleep-related deaths and suicides continue to be a leading cause of death for children in Georgia. There are statewide initiatives underway to provide awareness and prevention. Additional local efforts may also be included here.

[121] Some jurisdictions have previously opted to include the protocol for the local child fatality review committee within the local child abuse protocol. This would be an appropriate place to include this information if the jurisdiction so chooses.

[122] The Child Welfare Information Gateway provides a very comprehensive free manual which provides an overview of the treatment of sexually abused, physically abused, and neglected children. The manual may be found at https://www.childwelfare.gov/pubs/usermanuals/treatmen/.

[123] Therapy should be trauma-focused. Many providers utilize trauma-focused cognitive behavioral therapy (TF-CBT), which is widely regarded as the most effective treatment for sexually abused and traumatized children. Other treatment modalities that are trauma-focused may include, but are not limited to, talk therapy, play therapy, and animal assisted therapy.

The primary involved agency will coordinate referrals for evaluation, assessment, treatment and counseling.[124] If appropriate, the referring agency will complete demographic information and release of information forms needed by the provider. The Multi-Disciplinary Team (MDT) may assist in determining if there is a need of referral for treatment and treatment providers may participate in the MDT and/or the Local Interagency Planning Team (LIPT) to discuss findings and recommendations.

For physical abuse, sexual abuse, and neglect cases, the following are resources in Clayton County that may provide treatment:

- Southern Crescent Sexual Assault and Child Advocacy Center
  Office: 770/507-7772
  intake@scsac.org
- For sexual exploitation and human trafficking cases, contact the Child Advocacy Centers of Georgia(CACGA) at 1-866-END-HTGA (1-866-363-4842) to assist in the assessment and identification of appropriate services and resources.

For Superior Court cases, Adult Probation and Parole will coordinate referrals for perpetrator treatment[126] by state licensed clinicians. For Juvenile Court cases, DJJ will do the same.

VI. Additional Considerations

Secondary traumatic stress, vicarious trauma, compassion fatigue, and burnout.[127] It is important to recognize that professionals encountering child abuse as a nature of their work frequently experience emotional stress including Secondary Traumatic Stress (STS), vicarious trauma, compassion fatigue, or burnout. STS cannot be prevented since it is a normal human and universal response to helping victims of abnormal events such as violence and/or disasters, but negative STS effects can be prevented from developing into a more serious condition. Management of STS and similar emotional stresses is essential to mitigating its negative impact and individual coping skills can be developed that can assist in the management of these stressors and symptoms. Increasing awareness of STS as a normal part of child protection and welfare work, STS symptoms and risk factors, and protective factors and self-care strategies can help to mitigate the effects of STS. This awareness may serve to improve the work performance and retention of such professionals and reduce the stress-induced physical and mental health problems that may result from STS. All committee members should be educated about STS and similar stresses, recognizing that we each have our own adverse childhood experiences (ACEs) that may exacerbate some of the STS encountered. All committee members should also show each other and themselves compassion, understanding, and support to mitigate the effects of these stresses and build worker resiliency.[128]

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[124] The primary involved agency will provide additional assistance in selecting a provider based on the needs of the child, the financial resources of the family, and the availability of the provider. The provider selected should be a licensed clinician trained and experienced in the treatment of child abuse and trauma.

[125] The CAC provides the following services: *(insert services the CAC provides; these may include: forensic interviews; forensic evaluations; coordination of MDT meetings; court testimony; court preparation; individual therapy; group therapy; assessment and referrals; resource library materials; parent education/support groups; sexual abuse prevention education and training; lectures, workshops, and other educational presentations).* These services are offered in *(insert the language(s) offered by the CAC)* and are free of charge *(adjust this if there is a cost or potential cost for services)*.

[126] Treatment for perpetrators may involve an evaluation of the perpetrator's mental status and social and psychiatric history, and will include recommendations, which may involve counseling or other treatment.

[127] While these terms are technically slightly different in definition, each of them have similar effects on child welfare professionals and the prevention and intervention opportunities are largely similar.

[128] Resources include: https://www.acf.hhs.gov/trauma-toolkit/secondary-traumatic-stress; https://www.nctsn.org/trauma-informed-

care/secondary-traumatic-stress; https://ovc.ojp.gov/program/vtt/what-is-vicarious-trauma; https://www.compassionfatigue.org/; https://www.who.int/news/item/28-05-2019-burn-out-an-occupational-phenomenon-international-classification-of-diseases; https://www.ncbi.nlm.nih.gov/books/NBK279286/; https://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/burnout/art-20046642

VII. Resources

Refer to Appendix D - Local, State, and National Resources

VIII. Understanding and Agreement

The foregoing document reflects a cooperative effort on the part of Clayton County social services, mental health, education, and criminal justice organizations to continue to improve and refine their response to cases of child abuse in Clayton County.

The undersigned agency, department and judicial representatives commit themselves and their organizations to the implementation of the procedures as outlined in this protocol. It is understood that the adoption of this protocol is an ongoing process of cooperation and coordination to facilitate the effective handling of child abuse cases in Clayton County in such a way as to minimize trauma to the child and obtain effective remedies to prevent further abuse.

The protocol is not intended to, does not, and may not be relied upon to create any rights, substantive or procedural, enforceable at law by any party in any matter civil or criminal. The protocol shall not limit or otherwise restrict a prosecuting attorney in the exercise of his or her discretion nor in the exercise of any otherwise lawful litigative prerogatives. The law controls the provisions of the Protocol.

The signatories to this protocol are committed to continuing as an interagency committee as required by law and to periodically review and refine this interagency protocol for effectively preventing and responding to child abuse in Clayton County. In so doing, the protocol committee will identify critical issues, needs and resources required to facilitate and enhance the prevention, investigation, prosecution, and treatment of child abuse in Clayton County.

The protocol committee will meet at least semiannually for the purpose of evaluating the effectiveness of the protocol and appropriately modifying and updating the same and for the purpose of preparing and issuing its annual report required by law.

IX. Signatures

I, the undersigned, have received a complete copy of the Clayton County Child Multidisciplinary Investigations and Prosecution of Child Abuse, Sexual Abuse, and Sexual Exploitation Protocol and the Clayton County Adult Sexual Assault Protocol and agree to the contents contained therein. I understand that no member of this committee shall enter into any agreement that conflicts with this protocol or any other procedure required by law for compliance purposes of this committee.

E-SIGNED by Robert Mack
on 2023-08-03 07:59:11 EDT

E-SIGNED by Kevin Roberts
on 2023-08-02 16:23:01 EDT

E-SIGNED by Michael Garrett
on 2023-09-05 11:23:05 EDT

E-SIGNED by Brandon Criss
on 2023-09-05 11:15:30 EDT

E-SIGNED by Charles Brooks
on 2023-08-09 10:34:53 EDT

E-SIGNED by Tommy Henderson
on 2023-08-09 14:34:46 EDT

E-SIGNED by Dr. Mario Majette
on 2023-09-29 11:38:02 EDT

E-SIGNED by Anthony Whitmire
on 2023-08-02 16:30:48 EDT

E-SIGNED by Keisha Wright Hill
on 2023-08-02 14:32:22 EDT

E-SIGNED by Rick Webster
on 2023-08-16 15:20:00 EDT

E-SIGNED by Brian Byars
on 2023-08-02 14:26:37 EDT

E-SIGNED by Michael Crumpler
on 2023-08-09 10:49:41 EDT

E-SIGNED by Salvia Fox
on 2023-08-24 11:40:17 EDT

E-SIGNED by Todd Spivey
on 2023-08-08 12:45:00 EDT

E-SIGNED by Deneka Manning
on 2023-08-02 16:23:51 EDT

E-SIGNED by Connie Rogers
on 2023-08-16 10:17:37 EDT

E-SIGNED by Tim Sweat
on 2023-08-08 13:06:41 EDT

E-SIGNED by Mike Keener
on 2023-08-02 14:23:45 EDT

E-SIGNED by Dr. Anthony Smith
on 2023-08-14 12:48:01 EDT

E-SIGNED by Dr. Lee Adams
on 2023-08-02 15:57:39 EDT

E-SIGNED by Concilia Chilumuna
on 2023-08-04 16:01:51 EDT

E-SIGNED by Roy Lango
on 2023-08-16 11:43:01 EDT

E-SIGNED by Tasha Mosley
on 2023-08-02 14:44:40 EDT

E-SIGNED by Gayla Nobles
on 2023-08-02 14:28:22 EDT

E-SIGNED by Levon Allen
on 2023-08-02 16:38:26 EDT

E-SIGNED by Pat Altemus
on 2023-09-05 15:17:52 EDT

IX. **Appendices**

A. O.C.G.A. § 19-15-2 (Child Abuse Protocol Governing Legislation)
B. O.C.G.A. § 15-11-26 (Best Interest of the Child Factors)
C. Sample Annual Report
D. Local, State, and National Resources
E. Child Developmental Stages and Milestones
F. Prevention-Focused Protective Factors and Efforts
G. Potential Indicators of Abuse
H. DFCS Mandated Reporter Form
I. Additional Information Regarding Forensic Interviews and Evaluations
J. Children's Advocacy Centers of Georgia CSEC Response Team
K. Investigating Child Homicide Factsheet
L. Clayton County Training Addendum
M. Clayton County Child Advocacy Center (CAC) Protocol
N. SCSAC-CAC Forensic Medical Exam Protocol
O. Clayton County Child Fatality Review Protocol
P. Clayton County Adult Sexual Assault Protocol
Q. Southern Crescent SCSAC-CAC Forensic Medical Exam Protocol

APPENDIX A: O.C.G.A. § 19-15-2
(Child Abuse Protocol Governing Legislation)

§ 19-15-2. Protocol committee on child abuse; written protocol; training of members; written sexual abuse and exploitation protocol

(a) Except as provided in paragraph (3) of subsection (b) of this Code section, each county shall be required to establish a protocol for the investigation and prosecution of alleged cases of child abuse as provided in this Code section.

(b)

(1) The chief superior court judge of the circuit in which the county is located shall establish a protocol committee as provided in subsection (c) of this Code section and shall appoint an interim chairperson who shall preside over the first meeting, and the chief superior court judge shall appoint persons to fill any vacancies on the protocol committee.

(2) After the establishment of a protocol committee, the committee members shall elect a chairperson from the protocol committee's membership. The protocol committee shall be charged with developing local protocols for the investigation and prosecution of alleged cases of child abuse.

(3) When a judicial circuit is composed of more than one county, the protocol committee shall determine if it shall be established for each county in the judicial circuit or if it will serve all of the counties within the judicial circuit.

(c) (1) Each of the following individuals, agencies, and entities shall designate a representative to serve on a protocol committee established pursuant to paragraph (1) of subsection (b) of this Code section:

(A) The sheriff;
(B) The county department of family and children services;
(C) The district attorney for the judicial circuit;
(D) The presiding Juvenile Court judge;
(E) The chief magistrate;
(F) The county board of education;
(G) The county mental health organization;
(H) The chief of police of a county in counties which have a county police department;
(I) The chief of police of the largest municipality in the county;
(J) The county public health department; and
(K) The coroner or county medical examiner.

(2) Each of the following individuals, agencies, and entities shall designate a representative to serve on a protocol committee established pursuant to paragraph (3) of subsection (b) of this Code section:

(A) The sheriff of each county in the judicial circuit;
(B) The county department of family and children services of each county in the judicial circuit;
(C) The district attorney for the judicial circuit;
(D) The presiding Juvenile Court judge of each county in the judicial circuit;
(E) The chief magistrate of each county in the judicial circuit;
(F) Each board of education in the judicial circuit;
(G) The county mental health organization of each county in the judicial circuit;
(H) The chief of police of each county in the judicial circuit, if any;
(I) The chief of police of the largest municipality in the judicial circuit;
(J) The county public health department of each county in the judicial circuit; and
(K) The coroner or county medical examiner of each county in the judicial circuit.

(3) A representative of a local child advocacy center shall serve on a protocol committee established under paragraph (1) or (3) of subsection (b) of this Code section if one exists in such location.

(4) A representative of a sexual assault center shall serve on a protocol committee established under paragraph (1) or (3) of subsection (b) of this Code section if one exists in such location.

(5) In addition to the representatives serving on the protocol committee as provided for in paragraphs (1) through (4) of this subsection, the chief superior court judge shall designate a representative from a local citizen or advocacy group which focuses on child abuse awareness and prevention to serve on such protocol committee.

(6) If any designated agency fails to carry out its duties relating to participation on the protocol committee, the chief superior court judge of the circuit may issue an order requiring the participation of such agency. Failure to comply with such order shall be cause for punishment as for contempt of court.

(d) Each protocol committee chairperson shall be responsible for ensuring that written protocol procedures are followed by all agencies. Such person may be independent of agencies listed in paragraph (1) of subsection (c) of this Code section. The protocol committee may appoint such additional members as necessary and proper to accomplish the purposes of the protocol committee.

(e) The protocol committee shall adopt a written protocol which shall be filed with the Division of Family and Children Services of the Department of Human Services and the Office of the Child Advocate for the Protection of Children, a copy of which shall be furnished to each agency in the county handling the cases of abused children. The protocol shall be a written document outlining in detail the procedures to be used in investigating and prosecuting cases arising from alleged child abuse and the methods to be used in coordinating treatment programs for the perpetrator, the family, and the child. The protocol shall also outline procedures to be used when child abuse occurs in a household where there is violence between past or present spouses, persons who are parents of the same child, parents and children, stepparents and stepchildren, foster parents and foster children, or other persons living or formerly living in the same household. The protocol adopted shall not be inconsistent with the policies and procedures of the Division of Family and Children Services of the Department of Human Services.

(f) The purpose of the protocol shall be to ensure coordination and cooperation between all agencies involved in a child abuse case so as to increase the efficiency of all agencies handling such cases, to minimize the stress created for the allegedly abused child by the legal and investigatory process, and to ensure that more effective treatment is provided for the perpetrator, the family, and the child, including counseling.

(g) Upon completion of the writing of the protocol, the protocol committee shall continue in existence and shall meet at least semiannually for the purpose of evaluating the effectiveness of the protocol and appropriately modifying and updating the same. The protocol committee shall file the updated protocol with the Division of Family and Children Services of the Department of Human Services and the Office of the Child Advocate for the Protection of Children not later than the first day of September each year.

(h) Each protocol committee shall adopt or amend its written protocol to specify the circumstances under which law enforcement officers shall and shall not be required to accompany investigators from the county department of family and children services when these investigators investigate reports of child abuse. In determining when law enforcement officers shall and shall not accompany investigators, the protocol committee shall consider the need to protect the alleged victim and the need to preserve the confidentiality of the report. Each protocol committee shall establish joint work efforts between the law enforcement and investigative agencies in child abuse investigations. The adoption or amendment of the protocol shall also describe measures which can be taken within the county or circuit, as the case may be, to prevent child abuse and shall be filed with and furnished to the same entities with or to which an original protocol is required to be filed or furnished. The

protocol shall be further amended to specify procedures to be adopted by the protocol committee to ensure that written protocol procedures are followed.

(i) The protocol committee shall issue a report no later than the first day of July each year. Such report shall evaluate the extent to which investigations of child abuse during the 12 months prior to the report have complied with the protocols of the protocol committee, recommend measures to improve compliance, and describe which measures taken within the county or circuit, as the case may be, to prevent child abuse have been successful. The report shall be transmitted to the county governing authority, the fall term grand jury of the judicial circuit, the Office of the Child Advocate for the Protection of Children, and the chief superior court judge of the circuit.

(j) Each member of each protocol committee shall receive appropriate training within 12 months after his or her appointment. The Office of the Child Advocate for the Protection of Children shall provide such training.

(k) The protocol committee shall include a written sexual abuse and sexual exploitation section within its protocol which shall be filed with the Division of Family and Children Services of the Department of Human Services and the Office of the Child Advocate for the Protection of Children, a copy of which shall be furnished to each agency in the county handling the cases of sexually abused or exploited children. The sexual abuse and sexual exploitation section of the protocol shall outline in detail the procedures to be used in investigating and prosecuting cases arising from alleged sexual abuse and sexual exploitation and the procedures to be followed concerning the obtainment of and payment for sexual assault examinations. The sexual abuse and sexual exploitation section of the protocol shall be consistent with the policies and procedures of the Division of Family and Children Services of the Department of Human Services. The sexual abuse and sexual exploitation section of the protocol is not intended to, does not, and may not be relied upon to create any rights, substantive or procedural, enforceable at law by any party in any matter civil or criminal. Such section of the protocol shall not limit or otherwise restrict a prosecuting attorney in the exercise of his or her discretion nor in the exercise of any otherwise lawful litigative prerogatives.

APPENDIX B: O.C.G.A. § 15-11-26
(Best Interest of the Child Factors)

§ 15-11-26. Best interests of child

Whenever a best interests determination is required, the court shall consider and evaluate all of the factors affecting the best interests of the child in the context of such child's age and developmental needs. Such factors shall include:

(1) The physical safety and welfare of such child, including food, shelter, health, and clothing;

(2) The love, affection, bonding, and emotional ties existing between such child and each parent or person available to care for such child;

(3) The love, affection, bonding, and emotional ties existing between such child and his or her siblings, half siblings, and stepsiblings and the residence of such other children;

(4) Such child's need for permanence, including such child's need for stability and continuity of relationships with his or her parent, siblings, other relatives, and any other person who has provided significant care to such child;

(5) Such child's sense of attachments, including his or her sense of security and familiarity, and continuity of affection for such child;

(6) The capacity and disposition of each parent or person available to care for such child to give him or her love, affection, and guidance and to continue the education and rearing of such child;

(7) The home environment of each parent or person available to care for such child considering the promotion of such child's nurturance and safety rather than superficial or material factors;

(8) The stability of the family unit and the presence or absence of support systems within the community to benefit such child;

(9) The mental and physical health of all individuals involved;

(10) The home, school, and community record and history of such child, as well as any health or educational special needs of such child;

(11) Such child's community ties, including church, school, and friends;

(12) Such child's background and ties, including familial, cultural, and religious;

(13) The least disruptive placement alternative for such child;

(14) The uniqueness of every family and child;

(15) The risks attendant to entering and being in substitute care;

(16) Such child's wishes and long-term goals;

(17) The preferences of the persons available to care for such child;

(18) Any evidence of family violence, substance abuse, criminal history, or sexual, mental, or physical child abuse in any current, past, or considered home for such child;

(19) Any recommendation by a court appointed custody evaluator or guardian ad litem; and

(20) Any other factors considered by the court to be relevant and proper to its determination.

APPENDIX C: Sample Annual Report

PROTOCOL COMMITTEE - ANNUAL REPORT

County/Counties: **Judicial Circuit:**

Date of Submission: *(Pursuant to O.C.G.A. § 19-15-2(i) the protocol committee is issuing this annual report no later than the first day of July.)*

1. *(Evaluate the extent to which the child abuse investigations during the 12 months prior to the report have complied with the child abuse protocol):*

2. *(Recommend measure(s) to improve compliance):*

3. *(Describe which measures taken within the county to prevent child abuse have been successful):*

Activities/Concerns:

_____

Chair - Printed Name and Title

Address:

Phone:

Email:

The report shall be submitted to the:
1. County governing authority
2. Fall term grand jury of the judicial circuit
3. Office of the Child Advocate, 7 Martin Luther King, Jr. Drive, Suite 347, Atlanta, GA 30334
4. Chief superior court judge

APPENDIX D: Local, State, and National Resources

Local, state and national resources listed below promote the general welfare of children and families, provide prevention activities to children, families and the community, provide prevention of the recurrence of abuse and neglect, and support the work of CAP committees.

Local Resources:

Inv. Ponda Maine & Inv. Angie Clements, Clayton County CFR, 9151 Tara Blvd, Jonesboro, GA 30236 (770)477-3450

Clayton County Sheriff's Office, 9157 Tara Blvd, Jonesboro, GA 30236 (770)477-4413

Clayton County Police Department, 7911 N McDonough St, Jonesboro, GA 30236 (770)477-3747

Clayton State University Department of Public Safety, 2000 Clayton State Blvd, Morrow, GA 30260 (Edgewater Hall Room 207) (678)466-4050

College Park Police Department, 3717 College St, College Park, GA 30337 (404)761-3131

Forest Park Police Department, 320 Cash Memorial Blvd, Forest Park, GA 30297 (404)366-4141

Jonesboro Police Department, 170 S Main St, Jonesboro, GA 30236 (770)478-7407

Lake City Police Department, 5455 Jonesboro Rd, Morrow, GA 30260(404)366-8035

Morrow Police Department, 6311 Murphy Dr, Morrow, GA 30260 (770)961-4006

Riverdale Police Department, 6690 Church St, Riverdale, GA 30274(770)996-3382

Captain Ernest B. Mitchell and Sergeant Artmetrius Harris, Clayton County Public Schools Police Investigations, 1099 Battle Creek Rd, Jonesboro, GA 30236 (678)479-2650

Clayton County DFCS, 877 Battle Creek Rd, Jonesboro, GA 30236 (770) 473-2323, (770) 603-4600

Clayton County District Attorney's Office, 9151 Tara Blvd, 4th Floor, Jonesboro, GA 30236 (770)477-3450

Clayton County Office of the Solicitor General, 9151 Tara Blvd, 3SL01, 3rd Floor, Jonesboro, GA 30236 (770)477-3380

Clayton Medical Examiner's Office, 7911 N. McDonough Rd, Jonesboro, GA 30236 (770)347-0222

Clayton County Public Schools-Student Services, 1058 Fifth Ave, Jonesboro, GA 30236 (770)473-2700

Concilia Chilumuna, Clayton County Juvenile Court/ CASA, 9163 Tara Boulevard, Jonesboro, GA 30236, Telephone:(770)477-3270

Toni McDowell (attytgm1@gmail.com) and Lauraill Williams (lauraillw@gmail.com) Clayton County DFCS County Special Assistant Attorney General(s) (SAAGs)

Clayton County Juvenile Court-Intake Unit, 9163 Tara Blvd, Jonesboro, GA 30236, (770)473-5977

Clayton County Superior Court, 9151 Tara Blvd-Room #1CL25, Jonesboro, GA 30236 (770)477-3395

Clayton County Magistrate Court, 9151 Tara Blvd, Jonesboro, GA (770)477-3443

Clayton County Probate Court, 121 S McDonough St. #3, Jonesboro, GA 30236 (770)477-3299

Clayton County Health District, 1117 Battle Creek Rd, Jonesboro, GA 30236 (678)479-2223

Southern Crescent Sexual Assault and Child Advocacy Center, 2 West Main Street, Hampton, GA 30228 (770)507-7772

Clayton Center – Children, Young Adult & Family (Behavioral Health), 157 Smith St, Jonesboro, GA 30236 (770)478-2280

Zach Botkin, Deputy Chief Medical Officer, Clayton County Fire & Emergency Services, 7810 Hwy 85, Riverdale GA 30274 (770)347-0133

Securus House, Clayton County Association Against Family Violence, (770)961-7233 securushouse.org

State Resources:

- 2-1-1/United Way
  - 2-1-1: http://211online.unitedwayatlanta.org/
  - United Ways in Georgia https://www.unitedway.org/local/united-states/georgia#

- Barton Child Law and Policy Center at Emory Law School
  - http://bartoncenter.net/

- Center of Excellence for Children's Behavioral Health, Georgia Health Policy Center, Georgia State University
  - https://gacoeonline.gsu.edu/
  - 404-413-0075

- Children's Advocacy Centers of Georgia (CACGA)
  - https://www.cacga.org/
  - State CAC Network: 770-319-6888;
  - Human Trafficking Concerns: 1-866-END-HTGA (842-4842)

- Children's Healthcare of Atlanta, Stephanie V. Blank Center for Safe and Healthy Children
  - https://www.choa.org/medical-services/child-protection-advocacy-center

- Committee on Justice for Children, Judicial Council of Georgia/Administrative Office of the Courts
  - https://georgiacourts.gov/j4c/
  - 404-656-5171

- Georgia Bureau of Investigation (GBI):
  - https://gbi.georgia.gov/
  - 24 Hour Communications Center: 404-244-2600
  - Child Exploitation and Computer Crimes Unit: https://investigative-gbi.georgia.gov/investigative-offices-and-services/specialized-units/child-exploitation-and-computer-crimes-unit; 404-270-8870
  - Child Fatality Review: https://gbi.georgia.gov/CFR; 404-270-8715
  - Crisis Intervention Team: https://gbi.georgia.gov/divisions/crisis-intervention-team

- Georgia Crime Information Center (GCIC) for attorneys requesting information for trial preparation: gcic.attorneys@gbi.state.ga.us; 404-244-2639
- Sex Offender Registry: GCICSexOffenders@gbi.ga.gov; 404-270-8465

- Georgia Coalition Against Domestic Violence
  - https://gcadv.org
  - 404-209-0280

- Georgia Commission on Family Violence
  - https://gcfv.georgia.gov/
  - 404-657-3412
  - Hotline: 1-800-33-HAVEN (1-800-334-2836)

- Georgia Coroners Association
  - https://www.georgiacoronersassoc.org/

- Georgia Court Appointed Special Advocates (GA CASA)
  - https://www.gacasa.org/
  - 800-251-4012
  - info@gacasa.org

- Georgia Criminal Justice Coordinating Council (CJCC)
  - https://cjcc.georgia.gov/
  - 404-657-1956

- Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD)
  - https://dbhdd.georgia.gov/
  - 404-657-2252
  - Georgia APEX Program (school-based mental health services and supports): https://dbhdd.georgia.gov/georgia-apex-program
  - Georgia Crisis and Access (GCAL) Line: 1-800-715-4225 (24/7)
  - Mental Health for Children, Young Adults, and Families: https://dbhdd.georgia.gov/be-dbhdd/be-supported/mental-health-children-young-adults-and-families

- Georgia Department of Community Affairs (DCA)
  - https://www.dca.ga.gov/
  - 404-679-4840

- Georgia Department of Community Health (DCH)
  - https://dch.georgia.gov/
  - 404-656-4507

- Georgia Department of Community Supervision
  - https://dcs.georgia.gov/
  - 678-783-4337

- Georgia Department of Early Care and Learning (DECAL), Bright from the Start
  - http://www.decal.ga.gov/
  - 404-656-5957

- Childcare and Parent Services (CAPS) https://caps.decal.ga.gov/en/

- Georgia Department of Education (GaDOE)
  - https://www.gadoe.org/Pages/Home.aspx

- Georgia Department of Juvenile Justice (DJJ)
  - https://djj.georgia.gov/
  - 404-508-6500

- Georgia Department of Public Health (DPH)
  - https://dph.georgia.gov/
  - 404-657-2700
  - Babies Can't Wait (Early identification, screening, and intervention for children 0-3 for developmental delays and certain health conditions): https://dph.georgia.gov/babies-cant-wait; 404-657-2850
  - Children 1st (Early intervention services for children 0-5 who may be at risk for poor health outcomes and developmental delays): https://dph.georgia.gov/children1st; 404-657-2850
  - Children's Health: https://dph.georgia.gov/childrens-health; 404-657-2850
  - Women, Infants, and Children (WIC): https://dph.georgia.gov/WIC; 800-228-9173

- Georgia Division of Family and Children Services (DFCS)
  - www.dfcs.dhs.ga.gov
  - 1-855-GA-CHILD (1-855-422-4453)
  - Prevention and Community Support: https://dfcs.georgia.gov/services/prevention-and-community-support-section; gadfcs.prevention@dhs.ga.gov

- Georgia Early Education Alliance for Ready Students (GEEARS)
  - https://geears.org/
  - 404-410-8564

- Georgia Family Connection Partnership
  - https://gafcp.org/
  - 404-527-7394
- Georgia Legal Services Program
  - https://www.glsp.org/
  - 1-800-498-9469
  - Atlanta Legal Aid: https://atlantalegalaid.org/
  - Georgia Legal Aid https://www.georgialegalaid.org/

- Georgia Office of the Attorney General
  - https://law.georgia.gov/
  - 404-651-8600

- Georgia Office of the Child Advocate
  - www.oca.ga.gov
  - 404-656-4200

- Georgia Governor's Office of Student Achievement (GOSA)
  - https://gosa.georgia.gov/

- Georgia Vocational Rehabilitation Agency
  - https://gvs.georgia.gov/

- Get Georgia Reading Campaign for Grade Level Reading
  - https://getgeorgiareading.org/
  - GGR@gafcp.org

- Healthy Mothers, Healthy Babies
  - https://www.resourcehouse.com/hmhb/
  - 1-800-300-9003
  - thecoalition@hmhbga.org
  - Georgia Family Health Line (Help with finding services/referrals for medical care; interpreters available in 170+ languages): 1-800-300-9003

- Prevent Child Abuse Georgia (PCA GA)
  - https://abuse.publichealth.gsu.edu/
  - 404-413-1296
  - 1-800-CHILDREN (1-800-244-5373)

- Prosecuting Attorneys' Council of Georgia
  - https://pacga.org/
  - 770-282-6300
  - info@pacga.org

- Technical College System of Georgia (TCSG)
  - https://www.tcsg.edu/

- Together Georgia
  - https://togetherga.net/
  - 404-572-6170
  - office@togetherga.net

- University System of Georgia (USG)
  - https://www.usg.edu/

- Voices for Georgia's Children
  - https://georgiavoices.org/

National Resources:

- American Academy of Pediatrics
  - www.aap.org
  - 800-433-9016

- American Bar Association (ABA) Center on Children and the Law
  - https://www.americanbar.org/groups/public_interest/child_law/

- American Professional Society on the Abuse of Children (APSAC)
  - https://www.apsac.org/
  - 877-402-7722

- Capacity Building Center for States
  - https://capacity.childwelfare.gov/states/

- Centers for Disease Control (CDC)
  - https://www.cdc.gov/
  - Child Abuse and Neglect Prevention: https://www.cdc.gov/violenceprevention/childabuseandneglect/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fviolenceprevention%2Fchildmaltreatment%2Findex.html

- Center for the Study of Social Policy
  - https://cssp.org/

- Child Welfare Information Gateway
  - https://www.childwelfare.gov/

- Children's Bureau, an Office of the Administration for Children and Families (ACF)
  - https://www.acf.hhs.gov/cb

- Children's Defense Fund (CDF)
  - https://www.childrensdefense.org/

- FRIENDS National Resource Center for Community-Based Child Abuse Prevention (CBCAP)
  - https://friendsnrc.org/

- National Association of Counsel for Children (NACC)
  - https://www.naccchildlaw.org/

- National Association for Education of Young Children (NAEYC)
  - https://www.naeyc.org/

- National Center for Children in Poverty
  - https://www.nccp.org/

- National Center for Missing and Exploited Children (NCMEC)
  - https://www.missingkids.org/HOME
  - 1-800-THE-LOST (1-800-843-5678)

- National Center on Shaken Baby Syndrome
  - https://www.dontshake.org/
  - 801-447-9360
  - mail@dontshake.org

- National CASA/GAL Association
  - https://nationalcasagal.org/
  - 800-628-3233

- National Children's Advocacy Center
  - https://www.nationalcac.org/
  - 256-533-KIDS (5437)

- National Children's Alliance
  - https://www.nationalchildrensalliance.org/

- National Council on Child Abuse and Family Violence (NCCAFV)
  - https://www.preventfamilyviolence.org/
  - 202-857-9778

- National Council of Juvenile and Family Court Judges (NCJFCJ)
  - https://www.ncjfcj.org/

- National Domestic Violence Hotline
  - https://www.thehotline.org/
  - 1-800-799-SAFE (1-800-799-7233)

- National Fatherhood Initiative (NFI)
  - https://www.fatherhood.org/

- National Institute of Health
  - https://www.nih.gov/
  - National Safe to Sleep Public Education Campaign: https://safetosleep.nichd.nih.gov/

- Polaris Project
  - https://polarisproject.org/

- Prevent Child Abuse America
  - https://preventchildabuse.org/

- Prevention Institute
  - https://www.preventioninstitute.org/

- Rape, Abuse, and Incest National Network (RAINN)
  - https://www.rainn.org/

- Zero to Three
  - https://www.zerotothree.org/

APPENDIX E: Child Developmental Stages and Milestones

What most babies do by 2 months old:

- *Social/Emotional*
  - Begins to smile at people
  - Can briefly calm himself (may bring hands to mouth and suck on hand)
  - Tries to look at parent
- *Language/Communication*
  - Coos, makes gurgling sounds
  - Turns head toward sounds
- *Cognitive (learning, thinking, problem-solving)*
  - Pays attention to faces
  - Begins to follow things with eyes and recognize people at a distance
  - Begins to act bored (cries, fussy) if activity doesn't change
- *Movement/Physical Development*
  - Can hold head up and begins to push up when lying on tummy
  - Makes smoother movements with arms and legs

What most babies do by 4 months old:

- *Social/Emotional*
  - Smiles spontaneously, especially at people
  - Likes to play with people and might cry when playing stops
  - Copies some movements and facial expressions, like smiling or frowning
- *Language/Communication*
  - Begins to babble
  - Babbles with expression and copies sounds he hears
  - Cries in different ways to show hunger, pain, or being tired
- *Cognitive (learning, thinking, problem-solving)*
  - Lets you know if she is happy or sad
  - Responds to affection
  - Reaches for toy with one hand
  - Uses hands and eyes together, such as seeing a toy and reaching for it
  - Follows moving things with eyes from side to side
  - Watches faces closely
  - Recognizes familiar people and things at a distance
- *Movement/Physical Development*
  - Holds head steady, unsupported
  - Pushes down on legs when feet are on a hard surface
  - May be able to roll over from tummy to back
  - Can hold a toy and shake it and swing at dangling toys
  - Brings hands to mouth
  - When lying on stomach, pushes up to elbows

What most babies do by 6 months old:

- *Social/Emotional*
  - Knows familiar faces and begins to know if someone is a stranger

    - Likes to play with others, especially parents
    - Responds to other people's emotions and often seems happy
    - Likes to look at self in a mirror
- *Language/Communication*
    - Responds to sounds by making sounds
    - Strings vowels together when babbling ("ah," "eh," "oh") and likes taking turns with parent while making sounds
    - Responds to own name
    - Makes sounds to show joy and displeasure
    - Begins to say consonant sounds (jabbering with "m," "b")
- *Cognitive (learning, thinking, problem-solving)*
    - Looks around at things nearby
    - Brings things to mouth
    - Shows curiosity about things and tries to get things that are out of reach
    - Begins to pass things from one hand to another
- *Movement/Physical Development*
    - Rolls over in both directions (front to back, back to front)
    - Begins to sit without support
    - When standing, supports weight on legs and might bounce
    - Rocks back and forth, sometimes crawling backward before moving forward

What most babies do by 9 months old:

- *Social/Emotional*
    - May be afraid of strangers
    - May be clingy with familiar adults
    - Has favorite toys
- *Language/Communication*
    - Understands "no"
    - Makes a lot of different sounds like "mamamama" and "babababaa"
    - Copies sounds and gestures of others
    - Uses fingers to point at things
- *Cognitive (learning, thinking, problem-solving)*
    - Watches the path of something as it falls
    - Looks for things he sees you hid
    - Plays peek-a-boo
    - Puts things in her mouth
    - Moves things smoothly from one hand to the other
    - Picks up things like cereal o's between thumb and index finger
- *Movement/Physical Development*
    - Stands, holding on
    - Can get into sitting position
    - Sits without support
    - Pulls to stand
    - Crawls

*At 9 months old, the AAP recommends a general developmental screening.

What most children do by 1 year old:

- *Social/Emotional*
    - Is shy or nervous with strangers

    - Cries when mom or dad leaves
    - Has favorite things and people
    - Shows fear in some situations
    - Hands you a book when he wants to hear a story
    - Repeats sounds or actions to get attention
    - Puts out arm or leg to help with dressing
    - Plays games such as "peek-a-boo" and "pat-a-cake"
- *Language/Communication*
    - Responds to simple spoken requests
    - Uses simple gestures, like shaking head "no" or waving "bye-bye"
    - Makes sounds with changes in tone (sounds more like speech)
    - Says "mama" and "dada" and exclamations like "uh-oh!"
    - Tries to say words you say
- *Cognitive (learning, thinking, problem-solving)*
    - Explores things in different ways, like shaking, banging, throwing
    - Finds hidden things easily
    - Looks at the right picture or thing when it's named
    - Copies gestures
    - Starts to use things correctly; for example, drinks from a cup, brushes hair
    - Bangs two things together
    - Puts things in a container, takes things out of a container
    - Lets things go without help
    - Pokes with index (pointer) finger
    - Follows simple directions like "pick up the toy"
- *Movement/Physical Development*
    - Gets to a sitting position without help
    - Pulls up to stand, walks holding on to furniture ("cruising")
    - May take a few steps without holding on
    - May stand alone

What most children do by 18 months old:

- *Social/Emotional*
    - Likes to hand things to others as play
    - May have temper tantrums
    - May be afraid of strangers
    - Shows affection to familiar people
    - Plays simple pretend, such as feeding a doll
    - May cling to caregivers in new situations
    - Points to show others something interesting
    - Explores alone but with parent close by
- *Language/Communication*
    - Says several single words
    - Says and shakes head "no"
    - Points to show someone what he wants
- *Cognitive (learning, thinking, problem-solving)*
    - Knows what ordinary things are for; for example, telephone, brush, spoon
    - Points to get the attention of others
    - Shows interest in a doll or stuffed animal by pretending to feed
    - Points to one body part
    - Scribbles on his own

    - Can follow 1-step verbal commands without any gestures; for example, sits when you say “sit down”
- *Movement/Physical Development*
    - Walks alone
    - May walk up steps and run
    - Pulls toys while walking
    - Can help undress herself
    - Drinks from a cup
    - Eats with a spoon

*At 18 months old, the AAP recommends a general developmental screening and an autism screening.

What most children do by 2 years old:

- *Social/Emotional*
    - Copies others, especially adults and older children
    - Gets excited when with other children
    - Shows more and more independence
    - Shows defiant behavior (doing what he has been told not to)
    - Plays mainly beside other children, but is beginning to include other children, such as in chase games
- *Language/Communication*
    - Points to things or pictures when they are named
    - Knows names of familiar people and body parts
    - Says sentences with 2 to 4 words
    - Follows simple instructions
    - Repeats words overheard in conversation
    - Points to things in a book
- *Cognitive (learning, thinking, problem-solving)*
    - Finds things even when hidden under two or three covers
    - Begins to sort shapes and colors
    - Completes sentences and rhymes in familiar books
    - Plays simple make-believe games
    - Builds towers of 4 or more blocks
    - Might use one hand more than the other
    - Follows two-step instructions such as “Pick up your shoes and put them in the closet.”
    - Names items in a picture book such as a cat, bird, or dog
- *Movement/Physical Development*
    - Stands on tiptoe
    - Kicks a ball
    - Begins to run
    - Climbs onto and down from furniture without help
    - Walks up and down stairs holding on
    - Throws ball overhand
    - Makes or copies straight lines and circles

*At 2 years old, the AAP recommends a general developmental screening and an autism screening.

What most children do by 3 years old:

- *Social/Emotional*
    - Copies adults and friends
    - Shows affection for friends without prompting
    - Takes turns in games
    - Shows concern for a crying friend
    - Understands the idea of "mine" and "his" or "hers"
    - Shows a wide range of emotions
    - Separates easily from mom and dad
    - May get upset with major changes in routine
    - Dresses and undresses self
- *Language/Communication*
    - Follows instructions with 2 or 3 steps
    - Can name most familiar things
    - Understands words like "in," "on," and "under"
    - Says first name, age, and sex
    - Names a friend
    - Says words like "I," "me," "we," and "you" and some plurals (cars, dogs, cats)
    - Talks well enough for strangers to understand most of the time
    - Carries on a conversation using 2 to 3 sentences
- *Cognitive (learning, thinking, problem-solving)*
    - Can work toys with buttons, levers, and moving parts
    - Plays make-believe with dolls, animals, and people
    - Does puzzles with 3 or 4 pieces
    - Understands what "two" means
    - Copies a circle with pencil or crayon
    - Turns book pages one at a time
    - Builds towers of more than 6 blocks
    - Screws and unscrews jar lids or turns door handle
- *Movement/Physical Development*
    - Climbs well
    - Runs easily
    - Pedals a tricycle (3-wheel bike)
    - Walks up and down stairs, one foot on each step

What most children do by 4 years old:

- *Social/Emotional*
    - Enjoys doing new things
    - Plays "Mom" and "Dad"
    - Is more and more creative with make-believe play
    - Would rather play with other children than by himself
    - Cooperates with other children
    - Often can't tell what's real and what's make-believe
    - Talks about what she likes and what she is interested in
- *Language/Communication*
    - Knows some basic rules of grammar, such as correctly using "he" and "she"
    - Sings a song or says a poem from memory such as the "Itsy Bitsy Spider" or the "Wheels on the Bus"
    - Tells stories
    - Can say first and last name

- *Cognitive (learning, thinking, problem-solving)*
    - Names some colors and some numbers
    - Understands the idea of counting
    - Starts to understand time
    - Remembers parts of a story
    - Understands the idea of "same" and "different"
    - Draws a person with 2 to 4 body parts
    - Uses scissors
    - Starts to copy some capital letters
    - Plays board or card games
    - Tells you what he thinks is going to happen next in a book
- *Movement/Physical Development*
    - Hops and stands on one foot up to 2 seconds
    - Catches a bounced ball most of the time
    - Pours, cuts with supervision, and mashes own food

What most children do by 5 years old:

- *Social/Emotional*
    - Wants to please friends
    - Wants to be like friends
    - More likely to agree with rules
    - Likes to sing, dance, and act
    - Is aware of gender
    - Can tell what's real and what's make-believe
    - Shows more independence (for example, may visit a next-door neighbor by himself [adult supervision is still needed])
    - Is sometimes demanding and sometimes very cooperative
- *Language/Communication*
    - Speaks very clearly
    - Tells a simple story using full sentences
    - Uses future tense; for example, "Grandma will be here."
    - Says name and address
- *Cognitive (learning, thinking, problem-solving)*
    - Counts 10 or more things
    - Can draw a person with at least 6 body parts
    - Can print some letters or numbers
    - Copies a triangle and other geometric shapes
    - Knows about things used every day, like money and food
- *Movement/Physical Development*
    - Stands on one foot for 10 seconds or longer
    - Hops; may be able to skip
    - Can do a somersault
    - Uses a fork and spoon and sometimes a table knife
    - Can use the toilet on her own
    - Swings and climbs

Source: *https://www.cdc.gov/ncbddd/actearly/pdf/checklists/Checklists-with-Tips_Reader_508.pdf*
Additional resources:

- CDC's quick reference checklist for children birth to 5: https://www.cdc.gov/ncbddd/actearly/pdf/parents_pdfs/milestonemomentseng508.pdf
- 1-pager quick reference checklist for children birth to 5: http://aapdc.org/wp-content/uploads/2014/01/Early-Stages-Milestones-EN-2011.pdf
- Variety of checklists covering milestones and abilities: https://pathways.org/topics-of-development/milestones/checklists/
- American Academy of Pediatrics (AAP): https://www.healthychildren.org/English/ages-stages/Pages/default.aspx (need to click on each stage individually to learn more)
- AAP's schedule for well-child visits: https://www.healthychildren.org/English/family-life/health-management/Pages/Well-Child-Care-A-Check-Up-for-Success.aspx

APPENDIX F: Prevention-Focused Protective Factors and Efforts

Georgia's vision and goals promote a collective, strength-based approach that can help increase family assets, enhance child development, and reduce the likelihood of child abuse. This approach, known as Strengthening Families™, is based on engaging families, programs, and communities in building key protective factors, which are characteristics that make a parent or caregiver, child, or family more likely to thrive despite whatever risk factors (characteristics that make a parent or caregiver, child, or family more likely to experience a negative outcome) they might face.

All families benefit from having strong protective factors:

- Parental resilience: managing stress and functioning well when faced with challenges, adversity, and trauma.
- Social connections: positive relationships that provide emotional, informational, instrumental, and spiritual support.
- Knowledge of parenting and child development: understanding child development and parenting strategies that support physical, cognitive, language, social and emotional development.
- Concrete support in times of need: Access to concrete support and services that address a family's needs and help minimize stress caused by challenges.
- Social and emotional competence of children: family and child interactions that help children develop the ability to communicate clearly, recognize and regulate their emotions, and establish and maintain relationships.

Source: Georgia's Child Abuse and Neglect Prevention Plan. Review the entire plan here: https://dfcs.georgia.gov/document/publication/vision-child-and-family-wellbeing-georgia-canpp2020/download

Examples of preventive efforts:

- In-service training for all disciplines involved with this protocol
- Programs of public awareness and trauma-informed education for everyone in the community
- Home-based visiting programs; well-child medical appointments
- Assessments, evaluations, and services available through the Babies Can't Wait program
- Pre-K programs; school breakfast/lunch programs; after-school and summer programs
- Educational programs in schools, including those focused on sexual abuse prevention strategies and programs. (See Georgia's Child Sexual Abuse and Exploitation Prevention Technical Assistance Resource Guide (TARG) found here: https://abuse.publichealth.gsu.edu/targ/ for recommendations of evidence-based programs for educators to use to comply with the Georgia mandate contained in O.C.G.A. § 20-2-143(b) to provide sexual abuse and assault awareness and prevention education to students in kindergarten through grade nine.)
- Child care programs in high schools
- Parent education and support groups; parent aide services
- Counseling and treatment services, including for mental health, behavioral health, and substance use needs; Local Interagency Planning Teams (LIPTs)
- Programs that teach anger and stress management skills, impulse control, and problem solving skills; family violence prevention and intervention programs and services
- Substance use education and awareness programs, such as the DARE program

- Accountability courts; community-based risk reduction programs through the Juvenile Court system, such as those focused on Children in Need of Services (CHINS)
- Concrete support in times of need, including financial assistance
- Services available through Family Connection Partnership; literacy programs
- Programs, supports, and services available through churches; food pantries
- Programs to ensure parents, adults, and children have someone to listen to their concerns and link them to appropriate community resources
- Supports and services which help others build resilience and support social and emotional competence and social and community connections
- A community collaborative where stakeholders facilitate the sharing of ideas, expertise, and resources to meet needs and resolve issues

APPENDIX G: Potential Indicators[129] of Abuse[130]

Physical Abuse

- Unexplained bruises or welts on the face, lips, mouth, torso, back, buttocks, thighs, or injuries in various stages of healing. The bruises may be in clusters or in patterns. They may appear on several different surface areas. May include bald patches on scalp.
- Unexplained fractures/dislocations to various parts of the body, including long bones, ribs, skull, nose, and/or facial structure or in various stages of healing. Fractures may also include multiple or spinal fractures.
- Unexplained burns from cigars or cigarettes**,** especially on palms, soles, back or buttocks. This may also include immersion burns (sock-like, glove-like, or doughnut shaped on buttocks or genitals). Infected burns may indicate a delay in seeking treatment.
- Unexplained missing or loosened teeth.
- Inadequate explanation of how injury sustained or explanation is otherwise inconsistent with actual type of injury.
- Child wears concealing clothing, regardless of weather.

Neglect or Exploitation

- Underweight/hungry
- Exhibit poor growth patterns or a failure to thrive
- Have poor hygiene or inappropriate dress
- Consistent lack of supervision
- Have unattended physical or medical needs
- Obvious abandonment
- Bald patches on the scalp
- Poor school attendance or chronic lateness
- Parent lacks interest in child's activities

Factitious Disorder/Pediatric Condition Falsification/Munchausen Syndrome By Proxy (MSBP)/Medical Child Abuse

- Unexplained seizures
- Life threatening events
- Chronic unexplained symptoms that resolve when child is protected
- Family history of similar sibling illnesses, unexplained sibling illness, or suspicious circumstances surrounding a death
- Discrepancies between history, clinical findings and general health of child
- Unusual signs and symptoms that do not fit clinical diagnosis
- Repeated hospitalizations and evaluations with definite medical diagnosis

[129] This list of indicators is not exhaustive and these indicators may suggest abuse but any one indicator or multiple indicators may not necessarily mean that a child has suffered abuse. Indicators should be considered as red flags necessitating further inquiry.
[130] Refer to CHOA training for more in-depth discussion and training of medical signs of abuse; contact CHOA at 404-785-5004 or cpctraining@choa.org for additional information.

- Caregiver welcomes invasive medical testing and displays considerable medical knowledge
- Family history of similar sibling illnesses, unexplained sibling illness, or suspicious circumstances surrounding a death
- Rare or unexplained lab findings
- Falsification of medical history
- Repeated requests for sexual abuse evaluations, especially if previously addressed or no other indication of sexual abuse
- Passive, abusive, or defensive spouse/partner
- "Doctor shopping"

Endangering a Child

- Family violence
- Living in or frequenting a "meth house"
- Substance use by the mother during pregnancy
- Withdrawal symptoms in a newborn
- Driving under the influence with a child in the vehicle

Sexual Abuse

- Difficulty walking or sitting
- Torn, stained, or bloody clothing
- Pain, discomfort, swelling, or itching in the genital area
- Pain upon urination
- Bruises, bleeding, or lacerations in the external genitals or anus area
- Poor sphincter control in previously toilet-trained child
- Vaginal or penile discharge of a sexually transmitted infection
- Victims may act out sexually or on younger children
- Self-harm
- Infantile behavior
- Parent/caregiver has extreme reaction to sex education or prevention education in the schools

Sexual Exploitation

- Child frequently runs away
- Child is in possession of gifts/money, the origin of which is unknown
- Unexplained bruises or injuries
- New pattern of doing poorly in school or otherwise disengaged
- Sleeping in class
- Truancy and/or chronic absenteeism
- Gang involvement
- Changes in temperament/mood
- Withdrawn, uncommunicative, and/or isolated from family
- Not eating

- Little to no eye contact
- Substance use

Emotional Abuse[131]

- Regressive habits, such as rocking or thumb sucking in an older child
- Daytime anxiety and unrealistic fears
- Speech disorders
- Lags in physical development
- Failure to thrive
- Hyperactive/disruptive behavior
- Displays low self-confidence/self-esteem
- Parent has unrealistic expectations of child
- Parent consistently displays ridicule and shame toward child or does not reward, praise, or acknowledge child's positive qualities or achievements
- Blames and punishes child for things over which the child has no control
- Threatens the child with abandonment or placement in an institution

[131] "Emotional abuse" means acts or omissions by a person responsible for the care of a child that cause any mental injury to such child's intellectual or psychological capacity as evidenced by an observable and significant impairment in such child's ability to function within a child's normal range of performance and behavior or that create a substantial risk of impairment, if the impairment or substantial risk of impairment is diagnosed and confirmed by a licensed mental health professional or physician qualified to render such diagnosis. O.C.G.A. § 15-11-2(30).

APPENDIX H: DFCS Mandated Reporter Form

BRIAN P. KEMP
GOVERNOR

TOM C. RAWLINGS
DIVISION DIRECTOR

Georgia Child Protective Services Mandated Reporter Form

A report can be made by calling **1-855-422-4453**, 24 hours a day, 7 days a week, 365 days per year. A Case Manager will respond to your call quickly and gather necessary information needed to assess the child's safety.

Mandated Reporters also have three additional CPS reporting options. Please use only one CPS reporting option per family:

Option One: Complete your report on the CPS mandated reporter website at: https://cps.dhs.ga.gov. If you are using this option and received an autoreply from the website, please do not use other reporting options. We will process the report based on what you have provided or call you at the number you have on your report if we need additional information. Before you can register on the mandated reporter website, you must take a short, free online mandated reporter training offered by Pro Solutions training at: https://www.prosolutionstraining.com

Option Two: E-mail the report to **cpsintake@dhs.ga.gov**. You will receive an autoreply stating that the CPS report has been received. You will receive a return phone call within 2 hours if additional information is needed. Once the report is entered and stage progressed in SHINES, you will receive a mandated reporter letter via email. The mandated reporter letter is emailed to the email address you registered on the CPS website with. The return phone call satisfies the legal requirement to speak with a DHS employee. Please include on the report a number where you can be reached.

Option Three: Fax to **229-317-9663**. Once the report is entered and stage progressed in SHINES, you will receive a mandated reporter letter via email. The mandated reporter letter is emailed to the email address you have on your fax. You will receive a return phone call within 2 hours if additional information is needed. This return phone call satisfies the legal requirement to speak with a DHS employee. Please include on the report a number where you can be reached and your email address. To request a PDF version of the CPS form or mandated reporter letter, please contact customer_services_dfcs@dhs.ga.gov

Please note that you may be called for additional information regarding this report.

All reporters have the ability to make an anonymous report. Your information will be kept confidential and will not be shared. If court action is initiated, the case record may be subpoenaed as a result of court proceedings and the reporter cannot be assured confidentiality will be fully protected. It may be necessary for you to appear in court to protect the child. All reporters are immune from liability when the report is made in good faith.

DATE: Click here to enter text.

Time: Click here to enter text. **County where child resides:** Click here to enter text.

Location of child at time of report: Click here to enter text.
Reporter's Name, Title, Telephone, & e-mail address: Click here to enter text.
Reporter's Organization and Organization address: Click here to enter text.

Primary Caretaker of Child: Click here to enter text.
Address of Primary Caretaker: Click here to enter text.
Reporter's relationship to Child: Click here to enter text.

Additional person (and contact information) who can be contacted if you, the reporter, are not available and additional information is needed: Click here to enter text.
If you are the designated reporter for your agency (i.e. school counselor, law enforcement dispatch…), please indicate the primary staff-person in your organization who has firsthand knowledge of the suspected child maltreatment and/or knows the child and family. DFCS's ability to speak directly with those having firsthand knowledge of the suspected child maltreatment and/or knows the child and family is critical for assessment of short- and long-term safety and well-being of the alleged victim child.

Name, Contact Information and Best Time to Reach Staff-person with firsthand knowledge of child/family: Click here to enter text.

Family Name/Who has custody of child(ren): Click here to enter text.

Mother's Name: Click here to enter text. **RACE:** Click here to enter text. **DOB:**Click here to enter text.
SSN: Click here to enter text. Alleged Maltreator:Click here to enter text.

Mother's Residence: Click here to enter text.
Mother's Employment: Click here to enter text.
Mother's Telephone Number: Click here to enter text. **Marital Status:** Click here to enter text.

Father's Name: Click here to enter text. **RACE:** Click here to enter text. **DOB:** Click here to enter text.
SSN: Click here to enter text. Alleged Maltreator:Click here to enter text.

Father's Residence: Click here to enter text.
Father's Employment: Click here to enter text.
Father's Telephone Number: Click here to enter text. **Marital Status:** Click here to enter text.
LanguageClick here to enter text. **ALT Contact Info:** Click here to enter text.

If a school reporter, please indicate all Emergency Contact information on file with the school and date this information was obtained from family: Click here to enter text.

CHILDREN

Child's Name	Victim	Sex	Race	DOB	SSN	Grade Level

OTHER HOUSEHOLD MEMBERS:

Name	Relationship to Primary Caretaker	Language	Marital Status	Race	DOB	SSN	Maltreator

OTHER ADULTS OF SIGNIFICANCE NOT RESIDING IN HOME:

Name	DOB	SSN	Relationship to Primary Caretaker	Language	Marital Status	Race	Address/Phone number	Maltreator

Would you like to be notified if an investigation is completed and whether abuse is substantiated or unsubstantiated? Please indicate Yes _____ or No _____

Is the either parent/guardian active military?

Yes _____ No _____

Location/Station (if yes): Click here to enter text.

Does the child and/or parent/primary caregiver have, or is believed to have, American Indian heritage?

_____Yes _____ No _____ Unknown

Tribe Information (if yes): Click here to enter text.

To your knowledge, has anyone in the home either recently or currently been ill or running a fever?

_____Yes _____ No _____ Unknown

The following information is critical to ensuring that we respond appropriately to this report of suspected child maltreatment. The importance of you supplying as much and as detailed information as possible for each of these areas cannot be stressed enough. (The sections will expand to accommodate as much information as you enter.) Please provide the following information in the Narrative section below:

Please tell how the maltreator neglected or abused the child. Click here to enter text.

How has the neglect or abuse harmed/affected the child? Click here to enter text.

How do you know this information? Click here to enter text.

When did this abuse or neglect last occur? Click here to enter text.

Is this likely to occur again? Click here to enter text.

Is this child in any danger now? Click here to enter text.

Does the maltreator have access to this child now? Click here to enter text.

Where is the child at this time? Click here to enter text.

Family supports, worker safety concerns, or other comments: Click here to enter text.

APPENDIX I: Additional Information Regarding Forensic Interviews and Evaluations

Forensic interviews and evaluations are conducted in a sensitive and unbiased manner that will support accurate and fair decision-making in the criminal justice and child protection systems. Forensic interviews are developmentally, culturally, and linguistically appropriate and allow for the child's narrative recall of events.[132] They are also conducted in a legally defensible manner, as no leading or suggestive questions are asked, and are video recorded. Additionally, they are designed to overcome potential legal obstacles related to the competence and objectivity of the interviewer; the quality of the interview; a child's developmental stage and varying ability to recall events and use specific language; and the impact of the trauma on the child.

In general, a forensic interview is most appropriate for children aged 3-17 or 18 and over if the child is still in high school who have either 1) suffered physical abuse with injuries, severe negligence, emotional abuse, sexual abuse, or sexual exploitation[133], or 2) witnessed any type of violence including, but not limited to, domestic violence, rape, or murder. A forensic interview is likely appropriate when a child has made a disclosure regarding abuse; has medical evidence of abuse; or exhibits behaviors suggestive of abuse. Forensic interviews may also be appropriate based on special circumstances that may include young adults disclosing abuse that occurred during childhood, or adults with special needs who may have experienced abuse or exploitation. Children who are insufficiently verbal for an interview but who present with medical evidence of sexualized behaviors should be referred for multi-disciplinary review.

Forensic evaluations are a series of forensic interviews (between 2-6 sessions, typically as dictated by the needs of the child) and may be planned from the beginning or decided upon the initial forensic interview. Forensic evaluations may be warranted/appropriate/necessary when a child was unable to complete the initial forensic interview and needs additional time or to fit a particular child's needs to engage/participate, which may be related to age, social/emotional/physical functioning, developmental/cognitive abilities or other special needs, ability to communicate, being multi-lingual and/or requiring an interpreter; multiple allegations, offenders and/or types of victimization, such as CSEC victims, long-term victims, or poly-victims; for those who have been severely traumatized; when the outcome of the initial forensic interview is inconclusive; or other reason when information could not be fully or effectively gathered in the single session. Forensic evaluations may also be needed when the child did not disclose abuse to investigators or during the initial forensic interview but there are other such concerning indicators or factors strongly suggesting possible victimization, such as sexualized behaviors, medical evidence or findings, statements of other children and/or adult witnesses, pornography, or access by known offender; child didn't disclose to investigators or during the initial forensic interview but allegedly disclosed to some other person; the child disclosed additional information following the initial forensic interview or indicated the reason he/she could not disclose; external evidence or corroboration emerges; prosecution and/or child protective decisions cannot be made based on the initial forensic interview results; or due to changes in the situation/ circumstances.

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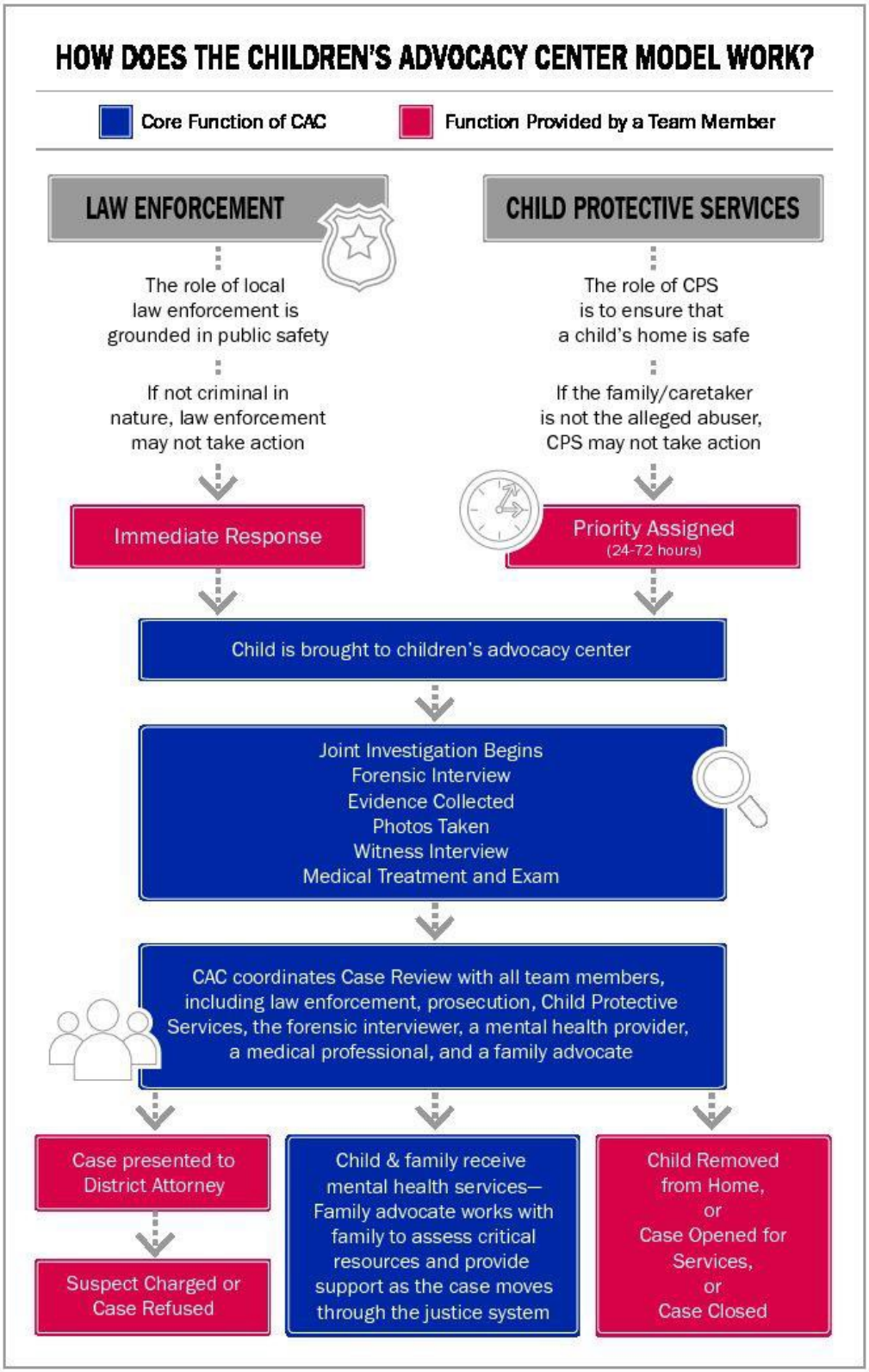
[132] Regardless of the number of sessions, best practice indicates that forensic interviews are: linguistically appropriate; purposeful in nature (a valid reason can be articulated for conducting more than one interview); forensically sound; non-duplicative; neutral and objective; child-friendly; child-focused; developmentally appropriate; and culturally competent.

[133] Although normally best practice suggests that children should have a forensic interview as soon as possible, interviews with children who have been sexually exploited may require an interval of time to assess their readiness to be interviewed. More than one forensic interview, or a forensic evaluation/extended forensic interview, may be required due to dynamics related to exploitation. The format and dynamics of interviews involving sexual exploitation may differ from sexual abuse cases due to additional special considerations such as: a history of sexual abuse, physical abuse, neglect and/or domestic violence in the home; victims not identifying themselves as victims; victims having a strong distrust of authority; victims fearing for the safety of their families or others due to threats made by their exploiter; and victims rejecting any outreach that is perceived as condescending.


HOW DOES THE CHILDREN'S ADVOCACY CENTER MODEL WORK?
Core Function of CAC
Function Provided by a Team Member
LAW ENFORCEMENT
CHILD PROTECTIVE SERVICES
The role of local law enforcement is grounded in public safety
The role of CPS is to ensure that a child's home is safe
If not criminal in nature, law enforcement may not take action
If the family/caretaker is not the alleged abuser, CPS may not take action
Immediate Response
Priority Assigned
(24-72 hours)
Child is brought to children's advocacy center
Joint Investigation Begins
Forensic Interview
Evidence Collected
Photos Taken
Witness Interview
Medical Treatment and Exam
CAC coordinates Case Review with all team members, including law enforcement, prosecution, Child Protective Services, the forensic interviewer, a mental health provider, a medical professional, and a family advocate
Case presented to District Attorney
Suspect Charged or Case Refused
Child & family receive mental health services—Family advocate works with family to assess critical resources and provide support as the case moves through the justice system
Child Removed from Home, or Case Opened for Services, or Case Closed

APPENDIX J: Children's Advocacy Centers of Georgia CSEC Response Team

Children's Advocacy Centers of Georgia

CSEC Response Team

24-Hour Hotline
1 (866) - END-HTGA
(363-4842)

Direct Line for Responders
(706)-850-7799

CSEC Response Team Services:

- Comprehensive Assessments
- Case Plans
- Forensic Interviews
- Specialized Medical Exams
- Advocacy
- Intensive Case Management
- Trauma Focused Therapy
- Information Referrals
- Website with a HIPAA Compliant referral form
  www.cacga.org or email referrals at referrals@cacga.org

CSEC Response Team Regions

North Region: DFCS Regions 1, 2, and 5
Metro Region: DCFS Regions 13 and 14
West Region: DFCS Regions 3, 4, and 6
East Region: DFCS Regions 7, 9, and 12
South Region: DFCS Regions 8, 10, and 11

APPENDIX K: Investigating Child Homicide Factsheet

BACK TO BASICS: INVESTIGATING CHILD HOMICIDE

THE CHILD ABUSE PROSECUTION PROJECT'S BACK TO BASICS SERIES

The Association of Prosecuting Attorneys' Child Abuse Prosecution Project is pleased to offer its Back-to-Basics Series, a "to-do" list for both new and experienced child abuse prosecutors and their multi-disciplinary teams.

This project was supported by Grant # 2019-CI-FX-K001 Awarded by the Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice. Points of view or opinions in this publication are those of the authors and do not represent the official position or policies of the United States Department of Justice.

To join our mailing list or for more information, please contact us at info@apainc.org

GOLDEN RULE: Every child fatality could be the result of child abuse. Proceed with each incident as if it were a homicide. Failure to do so could result in the loss or degradation of crucial evidence that could be used down the line to prosecute the case.

Arriving at the Scene

First Responders (Fire Department, EMTs, Paramedics, Patrol Officers, etc.)

First responders should keep the following in mind when arriving on scene:

Who was in the house when you arrived? Who was with the child at the time of the reported event? Who discovered the child? Note the demeanor of the caregivers.

What did the child look like when you arrived? What was the child wearing? Were there marks or injuries on the child prior to resuscitation? What happened? Obtain details. What did the caregiver do after the event or after finding the child?

When did the reported event or trauma happen? When was the child last seen active and well? When was the child last seen alive? Note that these are two distinct questions.

Where was the child located when you arrived? Where was child found by caregiver? Inspect for blood, vomit, feces, bottles, etc. nearby. Be observant about the environment around the child - are there any drugs/drug paraphernalia, could the child have accessed medications or toxic substances?

Why did the caregiver/other call 911? If delayed, who was the first person called? Why was there a delay?

How exactly was the child injured (if caregiver reported an injury)? Was the injury witnessed? By whom?

Information First Responders Should Get from Caregivers

- **Obtain basic information about the child**
  - Age
  - General health
  - Any medical problems (chronic diseases, recent illnesses, hospital visits, etc.)
- **Get a narrative** from when the child was last seen healthy to when the child was in this state
- **Obtain basic information about all of the child's caregivers** and their relationship to the child

Documentation of Your Involvement

- Document what you **did** at the scene
- Document what you **observed** at the scene
- Document what you did **NOT observe** at the scene if it seems relevant
- Document **what the caregivers told you**
- Make sure that you **do not move or remove** anything from the location

Investigation

Investigators (law enforcement agencies--police, sheriffs, DAs; child protective services; coroner/medical examiner's investigators)

Crime Scene

- Patrol officers need to preserve the scene for other investigators
  - Ensure no one is contaminating the crime scene or removing evidence
  - Log who came in when and where
- Do you need a search warrant?
  - Consult with the prosecutor's office to determine the scope of the warrant and items to be seized
- Document the scene
  - Take photographs/videotape the scene before moving anything or removing evidence
  - Take measurements
  - Seize any evidence potentially relevant to the crime, including:
    - Dangerous instruments, such as
      - Belts
      - Blunt objects
      - Sharp instruments, etc.
    - Bloodstained materials
      - Clothing
      - Rags
      - Diapers
    - Bedding
    - Clothing child was wearing at time of incident
    - Baby bottles
    - Drugs/paraphernalia
    - Medications
- Document what you did **NOT observe** at the scene if it seems relevant
- Document **what the caregivers told you**

> **PRO TIP:** Interviews done within hours of the child's discovery can be vital to the outcome of cases. You need to establish a timeline and who had exclusive access to and control of the child. These interviews should help you identify the responsible party/parties and assist in ruling out other caregivers or responsible parties.

Interviews

Parents and Caregivers

- Meet with caregivers separately
- Establish narrative about what happened from caregivers
  - Establish a precise timeline (hour by hour) for the last 24-48 hours or from the time that the child was last known to be well. For the purposes of this timeline, establish:
    - When was the child last seen well?
    - What was the child's sleep/nap schedule?
    - What were the child's hour-by-hour activities? Get as many details as possible.
      - What did the child do? Watch TV (what was on)? Play games (which games)?
    - What did the child eat? What time were meals?
    - Did the child complain of anything?
    - What did the caregiver(s) do during the last 24-48 hours?
    - Ask the caregiver to identify all individuals who visited the home or saw the child over the last 24-48 hours.
    - Determine whether caregiver has cell phone and/or computer. Try to obtain all passwords and determine whether written consent or search warrant is required (see *Technology and Records* section below)
    - Ask the caregiver if there was prior CPS/ACS involvement

- Establish a timeline (day by day) for the last week:
    - Where has the child been within the last week?
    - Who did the child see? Did the child visit any relatives? Day care? Neighbors?
    - Did the child stay or spend time with any friends or relatives outside the home?
    - Was the child in the care of any other adults during the week?

If the caregiver provides a history of trauma or injury:

- Establish precise details of the trauma or injury.
    - **Where** did the injury occur? At home? Playground? Etc.
    - **Who** was at the scene at the time of the injury? Who was with the child at the time of the reported injury? Was the injury witnessed? Who discovered the child?
    - **What** happened? What did the child look like? Did the trauma result in any visible marks or injuries? Where on the child's body? Did the caregiver treat the injuries in any way? What happened after the injury? Get a medical history of the child as well (was the child premature? Any medical issues at birth? When was last doctor's visit and what was the reason? Etc.)
    - **Did** the caregiver dial 911? When? If delayed, why? Who did they call first?

If there is a potential smothering/suffocation or no evidence of trauma and the child dies suddenly, determine the following:

- When was the child last seen alive?
- Where was the child put down? Were there blankets or pillows or anything around the child?
- What was the child wearing?
- What position was the child in when found?
- What position was the child put down in?
- What did the caregiver do in response to finding the child? CPR? Etc.
- Who did the caregiver call?
- Do recorded video reenactment with caregivers (consider using a doll for reenactment).
- Has the parent/caregiver ever had a child die suddenly and unexpectedly? If yes, obtain all applicable information.

Other Individuals

- Interview everyone else who had access to the child
- Interview everyone else who had knowledge of the child
- Interview all relatives
- Interview neighbors
- Interview day care, nannies, etc.

Establish Exclusive Custody

- Identify and interview all caregivers
- Obtain detailed information from each interviewee
- Compare interview data with medical data by reviewing with medical experts
- Determine the timeframe of injuries from your expert
- Make sure that the investigation includes accounting for anyone else who might have cared for the child during that time period - eliminate them as a possible source of any injuries the child may have sustained

Professionals Involved with the Case

Child Protective Services

- Have they been contacted? If not, immediately notify them
  - If your jurisdiction has a critical incident protocol for the Multidisciplinary Team (MDT), initiate immediately
- Identify and contact assigned CPS worker at beginning of investigation
  - Inquire and obtain information about current investigation
  - Collaborate on current case including providing information that would assist their investigation
  - Prior history and involvement, including domestic violence and child abuse
- Obtain records for current and all previous cases
- Maintain continuous communication with agency throughout investigation

Medical Professionals

- Talk to medical provider(s)
  - First responders/EMTs/Paramedics/Ambulance workers
  - Emergency department providers
  - Pediatrician (hospital providers and primary care physician)
  - Attending physician caring for the child and other relevant specialists
  - Nurses
  - EMS
  - Hospital social worker
- Obtain the following information:
  - What injuries were identified by the clinical physicians?
  - What medical diagnoses were made by the clinical physicians?
  - What is/was the leading diagnosis made by the hospital provider?
  - What is the basis of this diagnosis?
  - Are there other potential diagnoses (i.e. what are other potential causes for these injuries) and what rules these out?
- Obtain all medical records
  - Birth records, including mother's prenatal records
  - All pediatric medical records, including well and sick visits, ED and urgent care visits
  - Hospital records (including previous hospitalizations)
  - Radiographs, including skeletal surveys, CT and MRI scans, and other x-rays
  - Laboratory records
- Identify the following information:
  - Determine whether the child had any underlying medical problems.
  - Was the child healthy or ill in the days or weeks leading up to death?
  - Was the child seen by any providers in the days or weeks leading up to the child's death?

Medical Examiner/Pathologist/Coroner

- Detective/investigator must attend autopsy
- Assigned prosecutor should attend autopsy, if possible
- Provide ME/pathologist/coroner with all medical records, including hospital, primary care, and birth records
- Speak to ME/pathologist/coroner about initial clinical findings obtained from clinical physicians, including pending results from the hospitalization
- Speak to ME/pathologist/coroner about their initial findings and interpretations
  - Review photographs, slides, x-rays with ME/pathologist/coroner
  - Discuss possible causes of death and additional testing required and/or pending
- Determine and provide additional information that would assist with the ME/pathologist/coroner's final conclusions
- Facilitate visits to the location where the child died for ME/pathologist/coroner
- Should the ME/pathologist/coroner give an opinion that seems contradictory to the investigative information or to common sense, ask them to provide authoritative and credible medical evidence to support their opinion.

> **Pro Tip:** In addition to the treating physicians and pathologists, determine whether your case requires other medical experts to evaluate and provide assistance/ testimony. Potential experts include child abuse pediatricians, neurologists, toxicologists, burn specialists, ophthalmologists, odontologists, or others.

Technology and Records

- Obtain and listen to all 911 calls
- Identify the sources of technology that are likely to contain evidence, including: cell phones, computers, email accounts, cloud storage, text messages, digital photographs, social media accounts, cell phone geolocation, surveillance footage/nanny cams
    - Identify the specific carriers/companies responsible for the records of these resources
    - Send letters of preservation to all potential companies with identifying information to request they preserve records while you prepare formal process
- Seek appropriate search warrants/court orders/written consent from owner of device (i.e. cell phone, computer, etc.)
- Run criminal, domestic incident reports, and child abuse history searches for all relevant parties
- Run the address and prior addresses to determine if the police department had previous contact with that family

Once You Have Identified a Suspect

- Preparation is essential before conducting a suspect interview
    - Review case file and all available information
- As with all criminal cases, this is a search for the truth
- Great deliberation should be given to timing and specifics of conducting the suspect interviews
    - Do not interview potential suspects until you have a command of the facts and have spoken to the medical professionals
    - Determine which investigator/prosecutor is in the best position to get the most information from the suspect
    - Ensure entire interview session is videotaped
- One must get a detailed account of the suspect's narrative and compare that narrative to the other information obtained during the investigation
    - That includes speaking to the medical professionals to see if the suspect's narrative of events explains the medical findings
    - Do a taped reenactment of what happened using a doll
    - Compare the suspect's narrative to other witness interviews
    - Compare the evidence collected, including the technological data, to the suspect's narrative
- Do not arrest or authorize an arrest prematurely
    - Speak to the medical professionals and other members of the MDT
    - Consult with national and regional organizations for guidance and technical assistance
    - Any arrest decision should be made after careful deliberation and discussion between investigator and prosecutor

REMEMBER: These are challenging cases and not every case can be proven beyond a reasonable doubt. Communication, collaboration, attention to detail, and thorough investigation provide the best opportunity for determining the truth and obtaining justice.

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Appendix L – Clayton County Training Addendum

All mandated members agree to participate in on-going training related to the identification and intervention of child abuse. Such training equips members with skills needed to appropriately respond to child abuse allegations and determine needed prevention efforts.

Neglect and/or Maltreatment

Physical indicators

- Chronic hunger or tiredness
- Chronic health problems (i.e., skin, respiratory, digestive)
- Medical problems left unattended
- Inadequate hygiene (i.e., dirty and unwashed)
- Developmentally delayed (i.e., speech disorder, failure to thrive)
- Has been abandoned
- Without adult supervision for extended periods of time

Behavioral indicators

- Begging or stealing food
- Chronic fatigue (i.e., falling asleep in school, dull/apathetic appearance, listlessness)
- Poor school attendance or chronic lateness
- Coming to school early and leaving late
- Functions below grade aptitude level in school
- Delinquent/antisocial/destructive behavior (i.e., vandalism, inappropriate affection seeking, sucking/biting/rocking)
- Use of drugs/alcohol

Parent/Caregiver Behavioral Risk Factors

- Apathetic
- Craving excitement/change
- Desire to be rid of the demands of the child (i.e., isolates child for long periods of time, not listening or talking to child, leave child alone or unattended)
- Lack of interest in child's activities (i.e., fails to provide supervision and guidance, severely criticizes child, name calling, scaring, lack of affection)
- Lack of cooperation with agency

Environmental Risk Factors

- Lack of parenting skills
- Financial pressures
- Marital problems

- Inconsistent employment
- Mental health problems
- Drug/alcohol abuse
- Long term illness
- Chaotic family life
- Neglected as a child
- Poverty (i.e., low income, poor housing, isolation, large family)

Physical Abuse

- Physical abuse may be suspected in the injuries listed below are not associated with accidental injuries or if the explanation does not fit the pattern of the injury.
- Physical indicators
- Bruises (i.e., occurring in unusual patterns; occurring on posterior side of body; occurring in clusters; occurring on an infant, especially on the face; in various stages of healing)
- Burns (i.e., immersion burns, cigarette-type burns, restraint burns, appliance related burns, etc.)
- Unexpected missing or loosened teeth
- Unexplained lacerations and abrasions
- Inflicted marks (i.e., human bite marks, choke marks)
- Skeletal injuries
- Head injuries (i.e., absence of hair, nasal or jaw fractures, sub-dural hematomas, other more serious injuries)
- Internal injuries

Behavioral indicators

- Wary of adults
- Extreme behaviors (i.e., aggressive or withdrawn, frightened of sudden movements, apprehensive when other children cry)
- Reports injuries by parents (i.e., frightened by parents, afraid to go home)
- Wear long sleeves or other concealing clothing
- Child's explanation of injury is inconsistent with nature of injury
- Aggressive behavior toward children/animals
- Indiscriminately seeks affection

Parent/Caretaker Behavioral Risk Factors

- Unrealistic expectations of child
- Uses discipline which is inappropriate or extreme for child's age or behavior
- Discipline is often cruel
- Failed appointments (i.e., lack of cooperation with agency regarding child's health/injuries, reluctant to share information about child)
- Discourages social contacts
- Uses different medical facilities (i.e., refuses consent for medical exam/diagnostic testing)
- Fails to obtain medical care for child

- Believes in/defends corporal punishment
- Religious practices that pose the risk of child abuse
- Parent cannot be located
- Parent conceals child's injuries
- Parent confines child for extended periods of time

Environmental Risk Factors

- Parental history of child abuse
- Lack of parenting skills
- Marital problems
- Mental/physical illness
- Drug/alcohol problems
- Social isolation
- Financial pressures
- Unemployment
- Inadequate housing
- Target child in home (i.e., physically or emotionally handicapped, developmental disabled, unwanted)

Pediatric Condition Falsification

(Munchausen syndrome by proxy)

Pediatric Condition Falsification is a form of medical abuse initiated by a caregiver. It consists of chronic false reporting of symptoms and/or inducement of illness. The child is then unnecessarily exposed to medical interventions. The primary reason for this falsification of signs or symptoms in the child/victim by the perpetrator is called Factitious Disorder by Proxy. This is a psychiatric concept in which the adults seek attention at another's expense, and have the ability not only to lie but to imposture. An older term, Munchausen syndrome by proxy, refers to Pediatric Condition Falsification in which Factitious Disorder by Proxy is also present. In some instances, the non-perpetrating spouse or others help maintain the deceptive process by their failure to believe the doctors, blindly support the perpetrator, and/or at times actively collude with the deception.

PRESENTATION OF THE CHILD

- Physical condition
- Perpetrator directly inducing conditions (examples-vomiting or diarrhea induced by drug administrations, causing apnea by occluding the airway)
- Perpetrator deceptively reports signs and symptoms thereby misrepresenting the victim as ill (example-reporting seizure activity, symptoms reported by child appears healthy- such as high fevers).
- Perpetrator presents false evidence of illness (examples-blood placed in victims bodily fluids)
- Psychological condition

- Perpetrator reports false psychological symptoms (examples-excessive anxiety, school refusal, stress reactions, schizophrenia)
- Sexual Abuse
- Perpetrator repeatedly requests evaluation for false allegations of sexual abuse. This is Pediatric Condition Falsification although there is some dispute whether all cases are also Factitious Disorder by Proxy.

PRESENTATION OF PARENT/CARETAKER

- Goal is to gain attention for themselves
- Masquerade as the "good mother"
- Occasionally use the child to gain material good

PRESENTATION OF OTHER FAMILY MEMBERS

- Passive spouse
- Abusive spouse
- Help maintain deception by defending the perpetrator

OTHERS

- Doctors may be found who are more easily fooled and help to continue the deception
- "Doctor shopping" may occur to hide the deceptions (e.g. obtaining multiple medications) or to avoid a doctor getting wise to the situation
- Lawyers and judges may have problems recognizing this form of abuse as serious and propose plans that do not adequately protect the child's physical and emotional heath

Outcomes

- Up to 10% death rate in the literature - may be 2-5% in actuality
- Apparently all children will be emotionally damaged if return home to the perpetrator
- No plan for perpetrator seems to work

Sexual Abuse

- Physical indicators
- Difficulty in walking or sitting
- Complaints of pain or discomfort in genital area
- Torn/stained/bloody underclothing
- Unusual or offensive odors
- Poor sphincter control in previously toilet trained child
- Self-Mutilation, disfigurement
- Medical indicators (i.e., bruises/bleeding/laceration in genitalia or anus; genital or rectal pain, itching, or swelling; venereal disease; discharge; pregnancy; extreme passivity in a pelvic exam)

- Extreme weight gain/loss

Behavioral Indicators

- Sophisticated or unusual sexual knowledge and/or behavior (i.e., preoccupation with sexual organs of self/parent/other children, seductive behavior, sexual promiscuity, excessive masturbatory behavior, poor physical boundaries, perpetration to other children)
- Wearing many layers of clothing, regardless of weather
- Reluctance to go to a particular place or to be with a particular person
- Withdrawal/fantasy
- Infantile behavior
- Overly affectionate/indiscriminately seeks affection

Parent/Caretaker Risk Factors

- Marked role reversal between mother and child
- Extreme over protectiveness of the child
- Isolation of child from peer contact and community systems
- Domineering/rigid disciplinarian
- History sexual abuse for either parent
- Extreme reaction to sex education or prevention education in the schools
- Physical and/or psychological unavailability of mother
- Marital dysfunction
- Presence of unrelated male in home

Commercial Sexual Exploitation of Children (CSEC)

Indicators and Risk Factors

- Underage victims of sex trafficking are not readily apparent. Research by Stop it Now! Georgia stated 88% of children who are sexually abused never disclose their abuse while they're still children. (Hidden in Plain View)
- Unexplained absences from school
- Disengagement from education
- Signs of current physical abuse and/or sexually transmitted diseases
- Withdrawal or lack of interest in previous activities
- History of emotional, sexual, or other physical abuse
- Presence of older boyfriend/older male who is not a boyfriend
- Presence of tattoos 'marking her' as personal property

- Access to material things that they can't afford to purchase on their own (jewelry, new clothes, shoes, technology)
- Recurring STDs and other sexual health issues
- Changes in temperament/mood
- Drug and Alcohol Use
- Going out late and staying gone for days at a time; History of running away or current status as a runaway
- Displaying sexualized behavior
- Gang involvement
- Participation in chat rooms, instant messaging sites or social networking sites such as BackPage.com, Craigslist.com, Tagged.com, Facebook.com, etc.

According to the FBI, children who spend several hours online, particularly "latch-key" kids with little to no adult supervision, are at risk of being contacted by a sexual predator that might seek to exploit them either through pornographic images or physical encounters via e- mail, chat rooms, message boards, and other forums for online communication.

Emotional/Verbal Abuse

Physical indicators

- Regressive habits, such as rocking, thumb sucking in an older child
- Poor peer relations
- Daytime anxiety and unrealistic fears
- Behavioral extremes: either aggressive/antisocial or passive/withdrawn
- Problems sleeping at night, may fall asleep during day
- Speech disorders
- Learning difficulties
- Displays low self-confidence/self-esteem
- Sadomasochistic behavior (displays cruelty towards other children or animals, or seems to derive satisfaction from being mistreated)
- Lack of concern for personal safety, oblivious to hazards and risks

Parent/Caretaker Behavioral Risk Factors

- Unrealistic expectation of child
- Uses extreme discipline, overacts when child misbehaves or does not meet parents' expectations
- Consistently displays ridicule and shame towards child
- Does not reward, praise or acknowledge child's positive qualities or achievements

- Blames and punishes child for things over which the child has no control
- May use bizarre and inappropriate forms of punishment, such as isolating a child in a closet or humiliating a child in public
- Threatens the child with abandonment or placement in an institution

Environmental Risk Factors

- Parents were victims of some form of child abuse: physical, sexual, emotional
- Marital problems
- Isolated, no support system
- Low self-esteem
- Drug/alcohol problems
- Does not understand normal developmental stages of children
- Mentally/physically ill
- Financial/employment problems
- Child unwanted
- Family violence

All training designated to help professionals deal appropriately with children who have suffered abuse should include information found below. Professionals working with children are often unsure of the appropriate response to children who have been abused. Try to normalize the situation by acknowledging it as you would divorce, death, or other traumatic crisis in a child's life. Try not to dwell on the abuse or ignore inappropriate behavior. Your role is to help build the child's self-esteem and sense of safety and security. Some suggestions are:

A. Maintain contact with the child's caseworker, therapist, and non-offending parent when appropriate.

B. Be aware of such events as foster care placement and juvenile/criminal court proceeding.

C. Be sensitive to touching the sexually abuse child without asking permission.

D. Do not tolerate inappropriate sexual or violent behavior. Reassure the child that he/she is OK, but that the behavior is unacceptable.

E. If the child wants to talk more about the abuse, find a private place to listen, validate feelings, and continue to be supportive.

F. Respect the family's feelings and need for privacy. Do not discuss the abuse with persons involved.

G. Abused children especially need to hear self-esteem messages such as: "You are healthy", "You have every right to be here", "You have every right to be safe" or "You are brave for telling."

H. Recognize your need for support in dealing with your own feelings of pain, fear, anger, and powerlessness.

Appendix M – Clayton County CAC Protocol

Southern Crescent Sexual Assault and Child Advocacy Center
2 West Main Street
Hampton, GA 30228

O. 770/507-7772
Crisis Line. 770/477-2177

DFCS and Law Enforcement have committed to the joint investigation of child abuse cases, and to the coordination of the investigation of child physical and/or sexual abuse, and other cases deemed necessary, through a child advocacy center. Children who are reported victims of sexual abuse or physical abuse will receive a multidisciplinary response coordinated through Southern Crescent Sexual Assault and Child Advocacy Center. Joint investigationshall include cross-reporting of allegations, collaborative interviewing, and interdisciplinary case review.

Services provided by the Children Advocacy Center (CAC)

The Child Advocacy Centers offer the following services:

- Digitally recorded Forensic Interviews
- Coordination of Multidisciplinary Team (MDT) case review
- Expert Testimony
- Court Preparation
- Extended Forensic Interviews
- Individual Therapy and Group Therapy
- Forensic Medical Examinations
- Assessments and Referrals
- Community Education and Awareness Programs
- Professional Training

All of the above services are offered in English, however, can be provided in any other language to accommodate the client and families at no charge.

Forensic Interview Protocol

Forensic interviewing of reported victims of child abuse is an extremely specialized skill, which requires research-informed knowledge and specialized training in specific areas. Some of these areas include:

- children's memory and suggestibility
- children as witnesses
- interviewing techniques and process of inquiry
- process of disclosure
- dynamics of child sexual abuse
- child development
- use of anatomical dolls and diagrams
- characteristics of abuse and neglect
- exploration of alternative hypothesis
- effect of childhood trauma and stress
- recantation
- developmental, cognitive and physical issues associated with children with special needs
- dynamics associated with commercially sexually exploited children and teens

The competence and objectivity of interviewers and the quality of the interview itself are frequently the focus of abuse investigations. Trained interviewers should be utilized to conduct forensic sexual and physical abuse interviews of children. Interviewers should be trained in a nationally recognized forensic interview protocol such as Finding Words/ChildFirst, CornerHouse, or the National Children's Advocacy Center Forensic Interview model. Contact the CAC for information regarding forensic interview training opportunities.

Child Advocacy Center (CAC)

Interviews of children reported to be victims of child sexual and physical abuse should be conducted at a child advocacy center. Forensic interviewing is a practice continually enhanced by emerging research. Personnel from Law Enforcement and DFCS should make every effort to follow Southern Crescent Sexual Assault and Child Advocacy Center's procedures and to coordinate their investigative efforts in a manner which increases the efficiency of the investigation while minimizing additional trauma to the child.

Making Referrals

Children who have made a disclosure regarding sexual or physical abuse, or have medical evidence of abuse, or who exhibit behaviors suggestive of abuse should be referred for a joint forensic investigation of the abuse by DFCS, Law Enforcement (LE), or the District Attorney's Office. If a blank referral form is needed, contact SCSAC-CAC at 770/507-7772 or find the referral form on the website at scsac.org. The referral form needs to be filled outcompletely, or to the best of the referring agencies' knowledge, and submitted to intake@scsac.org.

Children 3 or under who are insufficiently verbal for an interview but who present with medical evidence or sexualized behaviors should be referred by LE and/or DFCS for interdisciplinary review by contacting Southern Crescent Sexual Assault and Child Advocacy Center.

Digitally recorded forensic interviews of children 3 - 18 should be conducted at a child advocacy center, and shall be scheduled at the request of DFCS, Law Enforcement, or District Attorney's Office personnel only.

If there is a circumstance(s) that involves children between the ages of 3-18 and it requires immediate response, please contact Southern Crescent Sexual Assault and Child Advocacy Center's 24-hour crisis line at 770/477-2177 if it occurs after our normal business hours. There may be instances where a case may not need immediate response and should be referred to the Southern Crescent Sexual Assault and Child Advocacy Center. Please complete a request for Forensic Service Form and submit to intake@scsac.org for interdisciplinary case coordination.

To ensure that all relevant information is obtained in the initial interview, all team members involved in the investigation should be present.

Receiving Referrals

Once the referral form is completed the referring agency will send the referral to intake@scsac.org. The intake coordinator will work with the investigative parties to ensure that the case is scheduled.

The Intake Coordinator will make contact with the non-offending caregiver and schedule the appointment. If the CAC cannot make contact with the caregiver after 3 attempts, the Intake Coordinator will staff the referral with the referring agency.

Digital Documentation

Digital documentation of Forensic Interviews with child victims and/or child witnesses of abuse or homicide are provided to appropriate agencies, including DFCS, Law Enforcement,and the District Attorney's Office. If investigative parties are not present at the time of the forensic interview, a records request form can be completed and submitted to records@scac.org to gain digital access.

Only investigative team members assigned to the case will have access to observe the interview from a separate viewing room. Once recording has begun, recording should not be discontinued until the interview is completed.

Forensic Interviews of Special Populations:

- Adults Over 18 years of Age with Developmental Delays
- Sexually Exploited Children
- Children with Special Needs (Cognitive and Physical)
- Children in Custody of Department of Juvenile Justice

Extended Forensic Interviews

Referrals may be made for children ages 3 to 18 when one or more of the following conditions present and when participation in the evaluation will not compromise the best interests of the child:

- The child did not disclose abuse to investigators but there are other such indicators strongly suggesting victimization, such as sexualized behaviors, medical evidence, statements of other children and/or witnesses, pornography, access by known offender, etc.
- The child did not disclose abuse to investigators but allegedly disclosed to some other person.
- Prosecution and/or child protective decisions cannot be made based on initial forensic interview results.

Multidisciplinary Meetings (MDT)

Southern Crescent Sexual Assault and Child Advocacy Center will coordinate multidisciplinary team (MDT) meetings for the primary purpose of facilitating communication between agencies involved in the investigation and prosecution of allegations of child abuse as well as those agencies responsible for protecting child victims. MDT staffing will provide agency members with a forum to discuss complex cases with other professionals, and as a result, will enhance both the decision-makingand intervention process. MDT meetings will take place a minimum of one time per month.

- Requests for cases to be staffed by MDT are accepted from any MDT member and/or appropriate agencies. Appropriate referral sources include, but are not limited to, DFCS, Board of Education, Law Enforcement, the District Attorney's Office, the Department of Juvenile Justice, CASA and medical and mental health personnel.
- MDT members may request to staff any case they believe can benefit from the collaborative input of the team. Requests can include cases involving children who were not seen for services at Southern Crescent Sexual Assault and Child Advocacy Center.
- MDT meetings will be held virtually or in person. An agenda identifying cases to be staffed at each meeting will be provided by the CAC atleast 5 business days prior to the scheduled meeting time.
- Because the purpose of the MDT staffing is to facilitate the sharing of information between agencies, all individuals from DFCS, Law Enforcement, prosecution, medical, and mental health that are involved with a case being staffed should be present.
- All agencies will cooperate fully in sharing information with each other concerning the abuse allegation, the child, and any other persons involved in the incident in order to fulfill their respective duties. Team members agree to maintain the confidentiality of information shared within the meeting, and not to divulge case-related information to anyone not directly involved in the investigation, prosecution, case management or treatment of the child. The agencies will assist each other in making the child available for interviewing if necessary to fulfill their duties and will inform each other immediately upon learning of a change of location, address, or phone number of the child.

Sexual Assault Medical Examinations

All children who are suspected victims of child maltreatment are entitled to a medical evaluation by a provider with specialized training. The collection and documentation of possible forensically significant findings are vital. However, the referral of children for medical examinations should NOT be limited to those for which forensically significant information is anticipated. Medical evaluations should be prioritized as emergent, urgent and non-urgent based on specific screening criteria. Criteria must be developed by specially trained and skilled medical providers or by local multidisciplinary teams that include qualified medical representation. Some children also benefit from follow-up examinations to re-assess findings and conduct further testing.

Medical providers at SCSAC-CAC willprovide medical evaluations of children 0-17 years of age who are suspected victims of child maltreatment, or who are significantly exposed to a suspected perpetrator of maltreatment.

Regardless of the type of child maltreatment initially reported, every child should receive a full, head-to-toe physical exam. The exam should address the possibility of more than one type of maltreatment occurring in the child. Goals of the general exam are:

- To ensure the health, safety, and well-being of the child
- To obtain the history from the child and/or guardian
- To consider alternative explanations for a concerning sign or symptom
- To identify and document evidence of injury or infection
- To diagnose and treat medical conditions resulting from abuse
- To identify and treat medical conditions unrelated to abuse
- To assess the child for any developmental, emotional, or behavioral problems needing further evaluation and treatment and make referrals as necessary
- To assess the child's safety and make a report to child protective services if needed
- To reassure and educate the child and family, as appropriate
- To document findings in such a way that information can be effectively and accurately presented, if requested by a social service or law enforcement agency

I. Appointments for medical examinations are made on a referral basis.

SCSAC-CAC accepts referrals from:

- Members of Georgia law enforcement agencies
- Department of Family and Children's Services
- The District Attorney's Office
- Medical staff from emergency department (with an investigative party)

II. During regular business hours, the referring agency should submit the Request for Forensic Service Form to provide the necessary intake information to intake@scsac.org to schedule the appointment. If the referring agency has a client who has been sexually abused within the past 120 hours or if the referring agency has questions about the timing of the medical evaluation, the referring agency should contact the SCSAC-CAC crisis line, 770/477-2177. SCSAC-CAC can receive acute (within the past 120 hours) forensic medical cases concerning child sexual abuse victims. The on-call advocate will contact the medical provider to discuss the case and schedule the exam. The medical provider is always available after-hours to conduct medical examinations when appropriate.

III. The CAC recommends that the following children receive a full medical exam by a practitioner with expertise in the medical evaluation of child maltreatment:

A. Sexual Abuse/Assault

- Any child who has disclosed sexual abuse involving any type of sexual contact (not restricted to 'penetration').
- A child for whom others have concerns of sexual abuse*
- Siblings and other children who live in the home of a suspected abuse victim, or who have had access to the alleged perpetrator.

* There may be rare exceptions to these recommendations. Before deciding against a medical exam, we recommend discussing the case with the CAC medical provider.

B. Physical Abuse

- Appropriate referrals include those children who do not have signs/symptoms of possible intracranial injury, acute fracture, abdominal trauma, significant burn or other serious medical condition requiring extensive evaluation and immediate treatment. Children with these concerns need to be evaluated in the Pediatric Emergency Department.
- Generally, suspected victims of physical abuse who should be seen at SCSAC-CAC includethose who have (or who are reported to have)
- Skin injuries (old or new) that do not require suturing or other medical procedure
- Siblings and other children who live in the home of a suspected abuse victim, or who have had access to the alleged perpetrator.

C. Neglect

- Any child for whom there are concerns of significant physical, environmental, supervisory, educational or emotional neglect, who do not require emergency medical treatment may have a medical evaluation at SCSAC-CAC. Often, these cases are best handled if they include not only a physical exam of the child/children but also a full case review of home photographs, law enforcement and DFCS records and medical records.
- Siblings of suspected neglect victims, and other children living in the home also need medical exams

IV. A child should be evaluated immediately at SCSAC-CAC if she/he:

- Has been sexually abused or assaulted within the previous 120 hours** (or has an unclear history but there is reason to believe the abuse/assault occurred within theprevious 120 hours)
- A child should be evaluated in the Pediatric Emergency Department if she/he:
  - Complains of abdominal pain, obvious vaginal/rectal bleeding, significant genital or rectal pain, or other medically concerning symptoms AND/OR
  - Has other medical problems requiring immediate attention.

**: Some caretakers may present with a suspicion of sexual abuse based on vague and nonspecific statements made by a very young child (i.e.: "my private hurts" expressed while the caregiver is washing the child's genitals), and/or minor and nonspecific physical findings ("her bottom looks red"). In most cases, these families can be referred to the CAC for the next available appointment and do NOT need to be evaluated immediately. However, should the referral source have any questions, he/she should call the CAC medical provider to discuss the case.

V. A child should be evaluated at the CAC, at the next available appointment if she/he:

- Has a history of remote sexual abuse (occurring more than 120 hours prior), without signs/symptoms of acute injury or abdominal pain.
- Lives in the home of a suspected abuse victim, or who have had access to the allegedperpetrator.

Sexual Abuse:

VI. If the child sexual abuse client was evaluated in the Emergency Department or primary care office by a person not trained in child abuse evaluations, we recommendfollow up as below: The referring agency will follow up with the CAC within 24 hours to discuss case and to coordinate appropriate scheduling. General guidelines include:

- Next day at CAC (primarily to document exam and look for injuries)
  - Acute child sexual abuse involving genital-genital contact or anal penetration
  - Acute child sexual abuse in which child reports significant pain or bleedingassociated with event
  - Acute or chronic child sexual abuse exam in which a positive finding is noted by primary care or Emergency Department medical provider (or if the medical provider has a question about a possible finding)
  - Chronic child sexual abuse with symptoms

- Exam within 72 hours of primary care or Emergency Department visit:
  - Acute child sexual abuse involving fondling only, with "negative" exam

- Exam at next available appointment (within 7 days if at all possible):
  - Chronic child sexual abuse with no symptoms or findings on primary care orEmergency Department exam
  - Child with sexualized behavior (even if they have already been seen by primarycare or Emergency Department)
  - Siblings of sexual abuse victims and other children living in the home, as well asother children, with whom an alleged perpetrator has had access, may need a forensic interview and/or medical exam.

- Exam in 2 weeks:
  - Acute child sexual abuse in pre-pubertal patients who need STI testing
  - Acute child sexual abuse in adolescents who were given prophylactic treatmentfor STI.

Physical Abuse

VII. Children who do not have an immediate need for treatment in the EmergencyDepartment should be scheduled as follows:

- If a child has visible recent injuries (or there is the report that he/she has), the child should be evaluated at the SCSAC-CAC the same day, if at all possible. If this is not feasible, it is critical that photographs of the injuries be obtained as soon as possible, typically by law enforcement. The child should be seen at SCSAC-CAC as soon as an appointment is available, and at that time the medical provider can review the photographs, as well as perform the exam.
- If there are no visible recent injuries and none suspected, the child should be seen at the next available appointment, to document possible scars or other evidence of abuse/neglect.
- Siblings and other non-index children should be evaluated at SCSAC-CAC according to theabove criteria (on same day if recent injuries are suspected; at next available appointment otherwise).

Neglect

VIII. Children who are suspected victims of neglect should be evaluated as soon as possible, in order to thoroughly document the current condition of the child and address conditions requiring treatment. Ideally this should be performed by an expert medical provider, but if a child is removed from the home at night, and/or needs extensive evaluation/treatment for an acute condition, he/she may need to be evaluated at the local Emergency Department.

Appendix N
Southern Crescent Sexual Assault and Child Advocacy Center
Forensic Medical Exam Protocol

All forensic medical examinations are conducted according to standards established by *A National Protocol for Sexual Assault Medical Forensic Examinations Adults/Adolescents (2013)* and *A National Protocol for Sexual Abuse Medical Forensic Examinations Pediatric (2016)*. In addition, all evidence collection is done using the Georgia Bureau of Investigation (GBI) Sexual Assault Evidence Collection Kit.

Special needs of victim (i.e., language barriers, disabilities, etc.)

1. Time period since assault occurred
2. Location of victim
3. Estimated time of arrival at
4. Special needs/requests of investigator

- If the victim goes to emergency department first, he or she should be medically cleared by the Emergency Department staff and then released to go to SCSAC-CAC for the sexual assault exam.
- If the victim has significant injuries or illness, or if the victim is highly intoxicated or potentially violent, they should be taken to the emergency department for medical clearance before the sexual assault exam.
- If necessary, the patrol officer/deputy/investigator should transport sexual assault victim to the exam location.
- At SCSAC-CAC, the patrol officer/deputy/investigator should remain in the building until the exam is completed.
- If the patrol officer/deputy/investigator cannot be at the office for the duration of the exam, a relief officer must be present for security purposes and to receive the sexual assault kit.
- Law enforcement should receive all evidence (rape kit, clothing, etc.) directly from the medical provider immediately after the examination.
- Officers/investigators should submit a medical record request form in order to receive copies of the medical record.

Chain-of-Custody and Evidence Integrity

Maintaining chain-of-custody is as important as collecting the proper evidence. Maintaining chain-of-custody is critical to prevent any possibility of evidence tampering and to preclude any doubt about the integrity of the evidence. Completed documentation is essential and must include the signature of everyone who had possession of the evidence from the individual who collected the evidence to the individual bringing the evidence into the courtroom.

The evidence must remain with the medical provider at all times. It is not necessary for a police officer to be in the exam room during the exam to maintain proper chain of custody. It is only necessary that the medical provider hand the completed evidence package directly to the investigator/officer at the end of the exam. Signatures of the medical provider and the investigator/officer on the chain-of-custody document will verify that the chain-of-custody has been maintained.

Additionally, in compliance with OCGA §17-05-74, the evidence package will be entered in the State

of Georgia CJCC Sexual Assault Kit Tracking System (SAKTS) by the medical provider as required for tracking purposes.

Appendix O – Clayton County Child Fatality Review Protocol

The unexpected death of a child creates a crisis for the family, friends, and community. In an attempt to reduce such tragedies, the Georgia Legislature mandated that each county establish a Child Fatality Review committee to review any sudden or unexplained death of a child under the age of 18. The Child Abuse Protocol committee will cooperate and work with the Child Fatality Review committee in investigations of all reviewable deaths, consistent with O.C.G.A. § 19-15-3 and 19-7-5, or other relevant code sections.

Structure

The Child Fatality Committee (CFR) previously established by law for each of the State's 159 counties has the responsibility for conducting fatality reviews.

Membership

Committee statutorily mandated members include:

The county medical examiner;

The District Attorney or his or her designee;

A Department of Family and Children Services representative;

A local law enforcement representative;

The Sheriff or county police chief or his or her designee;

A Juvenile Court representative;

A county public health department representative;

A county mental health representative.

Member Duties

CHAIRMAN:

- Accept report and notification from the county Medical Examiner's Office about the death of a child.
- Accept verbal report from Law Enforcement at the time of incident and refer for autopsy.
- Make a determination from the available resources, and according to the committee's criteria, of the cases to be reviewed by the committee.
- Forward notification of the death to the fire and emergency services committee member/representative.
- Distribute the list of cases to be reviewed to' the Committee' members.
- Arrange to have the necessary information from investigative reports, medical records, autopsy reports or other items made available to committee members.

- Schedule and notify the members of an upcoming review meeting.
- Serve as a liaison with each local agency, with other Child Abuse Protocol Committees and the State Fatality Review Panel.

CHAIR OF THE COMMITTEE MEETING:

- Ensure that all State Fatality Review Panel reporting, and data collection requirements are met including reports being forwarded the District Attorney and the State Fatality Review Panel.
- Oversee overall adherence to the committee review process.

LAW ENFORCEMENT:

- Report death, at time of discovery of incident, to DFCS, the Child Fatality Chairperson, and the Office of the District Attorney, including the District Attorney, the Chief Investigator, and the on-call Assistant District Attorney or the on-call District Attorney Investigator, no matter the time of the discovery of the incident.
- Provide primary case management of investigation where there is a question of possible criminal action.
- Coordinate with DFACS or other professionals involved in case management.
- Provide committee with materials from investigation or criminal record search; with information and statements, scene photographs, physical evidence, measurements, suspect information, etc.
- Act as Liaison with other law enforcement local and at the state level.
- Use the SUIDI death investigation form and the re-enactment doll for sleep- related infant deaths.

MEDICAL EXAMINER:

- Report death, at time of discovery of incident, to DFCS, the Child Fatality Chairperson, and the Office of the District Attorney, including the District Attorney, the Chief Investigator, and the on-call Assistant District Attorney or the on-call District Attorney Investigator, no matter the time of the discovery of the incident.
- Keep records on all deaths of children under their jurisdiction.
- Provide forensic information including autopsy reports and reports of their investigation.
- Provide interpretation for the committee of the cause and manner of death.
- Coordinate with law enforcement and other agencies involved with death.
- Provide the committee with a list of relevant cases in a timely manner. Upon receipt of an autopsy on a child under the age of 17 years, the County Medical Examiner shall immediately provide a copy of the autopsy to the chairperson of the committee.
- Act as Liaison with counterparts locally and at the state level.

COURT

- Liaison with the committee.
- Assist in legal issues.

DEPARTMENT OF FAMILY AND CHILDREN SERVICES:

- Provide investigation and intervention as necessary.
- Provide records and information of previous and present actions involving the child or family.
- Assist law enforcement in its investigation for possible criminal action.
- Interview siblings and others as indicated for protection of siblings and others as indicated for protection for surviving siblings.
- Provide follow up and support for surviving family members in abusive high-risk families with surviving children.
- Liaison with counterparts locally, in other counties and at the state level.

PHYSICIAN/PUBLIC HEALTH:

- Assist in interpretation of medical findings.
- Provide information on normal health and on child development.
- Assist in locating previous medical records.
- Liaison to the medical community.
- Provide a copy of the death certificate to the committee.

MENTAL HEALTH

- Assist with intervention for surviving family members.
- Assist with development of prevention programs.
- Liaison with the mental health community for resources including those affecting family violence and substance abuse.
- Provide an understanding for the committee of the intense personal emotions associated with child death.

EDUCATION

- Provide input about significant school records on deceased or siblings.
- Liaison with school personnel or resources for the family.
- Liaison with school personnel about their concerns about childhood death.

CITIZEN ADVOCATE

- Serve as a liaison with community groups.
- Assist with location of resources for prevention and intervention.
- Reduce "turf" issues by acting as an impartial participant representing the child, rather than any one government agency responsible for "handling the case".

OTHERS

- Regular members to be added may include pathologist, probation, parole, domestic violence, preschool, military, and researcher.
- Occasional members may include professionals and others that have a primary role with a given case, such as local law enforcement not on the committee but managing the case.

ACTIVATING THE REVIEW PROCESS

MEDICAL EXAMINER

1. The Medical Examiner shall notify the Chairperson of the death as soon as possible after he/she becomes aware of the situation.
2. The Medical Examiner shall forthwith without delay submit a copy of an Autopsy within 48 hours of receiving said autopsy to the Chairperson of the Child Fatality Review Committee.
3. The Medical Examiner shall include the name, address, date of birth, etc., so that committee members can look for previous records.

LAW ENFORCEMENT

1. Law Enforcement will contact DFCS, the Child Fatality Chairperson, and the Office of the District Attorney, including the District Attorney, the Chief Investigator, and the on-call Assistant District Attorney or the on-call District Attorney Investigator, no matter the time of discovery of incident.

THE FIRST 72 HOURS: INITIATING THE INVESTIGATION

Within 72 hours of notification of a child death, the CFR Chairperson will e-mail to all committee members all information obtained as of that time as to the specifics of the child's death.

The committee members will use the information contained in the report to determine if their agency has had any prior contact with the child and/or the child's family.

THE FIRST 30 DAYS

The CFR Committee will meet within 30 days of notification of the child's death.

Agencies that discover records on the case should notify the Chairperson as soon as possible.

THE SECOND 30 DAY PERIOD: CONDUCTING AND COMPLETING THE INVESTIGATION

The CFR's review is to be completed within 30 working days following receipt of all information including the autopsy reported if one is performed.

The Child Fatality Review Committee's investigation must address:

- The circumstances leading up to and case of death;
- Details of previous agency involvement including dates and reasons for service;
- Agency service prior to circumstances leading to death;
- Whether intervention had been sought;
- Conclusion of whether services prior to death were adequate;
- Whether death could have been prevented; and,
- Recommendations for prevention of future similar deaths.

THE THIRD 15-DAY PERIOD: TRANSMITTING THE REPORT

Following the completion of its investigation, the Child Fatality Review Committee will, within 15 days, transmit its report to DHR for the State Fatality Review Panel.

Under the following circumstances, a copy of the report will be sent within 15 days to the District Attorney having jurisdiction:

1. SIDS with no autopsy;
2. Accidental death that could have been prevented in intervention or supervision;
3. Sexually transmitted disease (or other evidence of sexual abuse by genital injury or history);
4. Medical causes that could have been prevented through intervention by agency or by seeking medical treatment,
5. Suicide of a child in custody known to DHR or suspicious;
6. Suspected or confirmed abuse;
7. Trauma to the head or body (by possible assault) and;
8. Homicide

The report will include minority opinions of disagreement.

REVIEW PROCESS

1. Chairperson will send case names and other identifiers to appropriate committee members.
2. Agencies will collect their own records, if any; and share significant case information with committee or case manager as soon as possible.
3. Committee will meet to review collective findings.
4. Formal case presentations may be made by representatives of different disciplines using a format consistent with their own professional training and experience.
5. Committee will discuss each question required by law.
6. Team will arrive at an agreement and, when necessary, provide space for minority opinion.
7. Panel report will be submitted.

If additional investigation is requested by the group, then a report will be written and sent to appropriate parties.

DISAGREEMENTS

Disagreements about membership or reports should be resolved by the committee.

Disputes may be referred to the Chief Judge of the Superior Court.

LOCAL REPORT FORMS

The form shall include space for all the questions noted above.

The DFCS child death form shall be added, when available to the case file of the Committee.

Records for the committee shall be stored in such a way to maintain the integrity of the case file.

Larger counties may need to computerize their record systems.

RELATIONSHIP TO STATE

The Chair of the committee shall serve as a State contact for the committee with expectations made by the Committee.

Agencies shall still contact their own State counterpart Agency.

The State will have responsibility to let the local Committee know about disagreements or problems with the cases reported.

CHILDREN EXPRESSING SUICIDAL THOUGHTS AND ACTS

When any agency receives a report that a child 17 year of age or younger has expressed suicidal thoughts or threats, then that agency should send a copy of the report to the School District to the attention of a School Social Worker.

Appendix P- Clayton County Adult Sexual Assault Protocol

This Clayton County Adult Sexual Assault Protocol ("Protocol") is adopted pursuant to O.C.G.A. § 15-24-2 for the purpose of outlining the procedures to be used in responding to, investigating, and prosecuting cases of sexual assault. The purpose of this Protocol shall be to ensure coordination and cooperation between all agencies involved in sexual assault cases so as to increase the efficiency of all agencies handling such cases and to minimize the stress created for the alleged sexual assault victim by the legal and investigatory process.[1]

For purposes of this Protocol, the term "victim" shall refer to adult victims.

1. ADVOCACY

The role of the sexual assault victim advocate[2] is to provide services to the victims of sexual assault regardless of whether or not the victim chooses to participate in the criminal justice process. They play a very important role in providing a response that keeps the victim central in the process, allowing the investigation and prosecution to be offender focused. Advocacy also has a critical role in promoting the healing process for the victim. Sexual assault victim advocates provide crisis intervention, support, information and referral, and other ancillary services to assist the victim through the criminal justice process. The support provided by the sexual assault victim advocate also benefits the criminal justice process because supported, well-informed victims are more likely to continue through the process. Advocates will operate under the guidelines established by *The Georgia Crime Victim's Bill of Rights* (O.C.G.A. § 17-17-1) and Georgia Sexual Assault Certification Standards.

Responsibilities of the sexual assault victim advocate include:

- Being available to victims 24 hours a day, 7 days a week in person and via a 24-hour crisis line staffed by trained community advocates
- Providing services to victims that are culturally competent and sensitive to the unique barriers some victims encounter in reporting sexual assault crimes
- Providing options to victims so that they may make informed decisions
- Supporting victims who choose to report to law enforcement by providing a link to eliminate barriers effecting the victim's participation in the criminal justice process
- Maintaining victim confidentiality
- Offering services to non-reporting victims and assisting if and when the victim decides to report

  Victims may also work with victim advocates from the Clayton County Victim Witness Assistance Program if the case progresses through the criminal justice system to the point of prosecution.

2. LAW ENFORCEMENT

The role of the investigating officer is to ensure the safety of the victim and the community and to ascertain if the report of sexual assault meets the elements of a crime under Georgia law. Within their jurisdictions, law enforcement shall be responsible for the investigation of sexual assault crimes.

Investigative responsibilities include:

- Identification, apprehension, and interrogation of suspect(s)
- Interview of victim with an offender focused and trauma informed approach, which shall include allowing an advocate to be present with the consent of the victim
- Interview of witnesses
- Collection and preservation of evidence
- Maintenance of chain of custody
- Timely submitting sexual assault evidence collection kits to GBI crime laboratory regardless of whether a suspect has been identified, per GBI recommendations
- Review of GBI crime laboratory reports as soon as possible after they are released to investigating agency, per GBI recommendations
- Determination of probable cause and arrest
- Preparation of case reports with investigative summaries
- Assistance to District Attorney's office in prosecution of case
- Testimony and presentation of evidence in court

Investigating officers will work with victim advocates to ensure a victim centered response to the investigation and proper notification of case updates to victims. Additionally, law enforcement officers will operate under the guidelines established by *The Georgia Crime Victim's Bill of Rights* (O.C.G.A. § 17-17-1).

3. MEDICAL FORENSIC EXAMINATION PROCEDURES

The role of the medical forensic personnel is to provide a timely, high-quality medical forensic examination that can potentially validate and address sexual assault patients' concerns, minimize the trauma they may experience, and promote their healing. At the same time, it can increase the likelihood that evidence collected will aid in criminal case investigation, resulting in perpetrators being held accountable and further sexual violence prevented.

Medical forensic examinations shall be performed at Southern Crescent Sexual Assault and Child Advocacy Center. Medical forensic exams should be made available if adult patient chooses to report, chooses not to report, or chooses to report anonymously.

Every effort should be made for medical forensic examinations to be completed by a Sexual Assault Nurse Examiner ("SANE"), physician, nurse practitioner or physician's assistant ("PA") trained in performing such exams.

Medical forensic responsibilities include:

- Obtaining informed consent from the patient for the medical forensic examination, documentation, and evidence collection
- Gathering the medical forensic history
- Conducting a physical examination
- Coordinating treatment of injuries
- Documentation of biologic and physical findings
- Collection of evidence from the patient
- Documentation of findings
- Providing information, treatment, and referrals for STIs, pregnancy
- Follow-up as needed for additional treatment and/or collection of evidence
- Providing testimony at trial

4. BIOLOGIC EVIDENCE COLLECTION

The SANE, physician, nurse practitioner, or PA will collect biologic samples at the request of a patient, in accordance with currently accepted protocol (defined as the *National Protocol for Sexual Assault Medical Forensic Examinations*), to obtain timely biologic reference samples for possible analysis at the GBI crime lab. At the conclusion of the sexual assault medical forensic examination, any evidence collected will be packaged and protected in a manner to ensure the integrity of specimens and the appropriate chain of custody of the evidence.

All biologic evidence will be collected up to a maximum of 120 hours after assault. In addition, cases should be evaluated on an individual basis as the medical forensic examination may be completed beyond 120 hours. For all such cases exceeding the 120-hour time frame, a referral should be made to the Southern Crescent Sexual Assault and Child Advocacy Center.

All biologic samples, fluids, hairs, and other evidence requiring GBI analysis will be given directly to the case investigator for processing using a proper chain of evidence.

All biologic evidence collected at the request of a patient who chooses not to initiate and participate in and/or cooperate with a law enforcement investigation shall be retained by the investigating officer in the evidence room for a minimum of one year. Such biologic evidence shall not be sent to GBI.

5. REQUESTS FOR MEDICAL FORENSIC EXAMINATION

With the consent of the patient, medical forensic examinations can be performed at the request of (1) a law enforcement agency, (2) the District Attorney's office, (3) the medical examiner or coroner's office, (4) a hospital, (5) pursuant to a court order, or at the patient's request pursuant to O.C.G.A. § 17-5-72.

Medical forensic examinations may be requested 24 hours a day by using the following procedure:

- Patrol officer/deputy/investigator should contact the Southern Crescent Sexual Assault and Child Advocacy Center via the 24 Hour Crisis Line at 770-477-2177
- Patrol officer/deputy/investigator should relay the following information to the Southern Crescent Sexual Assault and Advocacy Center's advocate, if possible:
    - Name of officer and investigator assigned to the case
    - Name of law enforcement agency, to confirm jurisdiction
    - Gender and age of victim
    - Special needs of victim (i.e., language barriers, disabilities, etc.)
    - Time period since assault occurred
    - Location of victim
    - Estimated time of arrival at Hampton office
    - Special needs/requests of investigator (i.e., to interview victim prior to exam, etc.
    - ** The advocate on call will need to speak to the victim to receive verbal consent and explain the process and assess injury.
    - Ask the victim to refrain from washing, bathing, showering, brushing teeth, using mouthwash, smoking, eating, drinking, douching, urinating, or defecating to prevent the loss of valuable physical evidence. **PLEASE NOTE: None of these actions prevent the ability to collect or discover potential evidence following a sexual assault. As per O.C.G.A. 17-5-72, All victims have the right to a sexual assault kit.**

- If victim goes to emergency department first, he or she should be medically cleared by the Emergency Department staff and then released to go to the Hampton office for the rape exam
- If necessary, the patrol officer/deputy/investigator should transport sexual assault victim to the exam location
- At the Southern Crescent Sexual Assault and Child Advocacy Center, the patrol officer/deputy/investigator should remain in the building until the exam and interview are completed
- If the patrol officer/deputy/investigator cannot be at the office for the duration of the exam, a relief officer must be present for security purposes

- Law enforcement should receive all evidence (rape kit, clothing, etc.) directly from SANE or Southern Crescent Sexual Assault and Child Advocacy Center staff
- Officers should contact Southern Crescent Sexual Assault and Child Advocacy Center at 770-507-7772 to arrange for pick-up of medical records

If a victim is injured, highly intoxicated, or potentially violent, he or she should be taken to the hospital, rather than the Hampton office.

6. COSTS OF THE MEDICAL FORENSIC EXAMINATIONS

The cost of examinations shall be paid pursuant to O.C.G.A. § 16-16-1(c), O.C.G.A. § 17-5-72. Patients shall not be responsible for the payment of medical forensic examination costs.

7. CONDUCT OF THE MEDICAL FORENSIC EXAMINATION

A SANE, physician, nurse practitioner, or PA will perform the examination and assessment.

Medical forensic examinations and biologic evidence collection should be completed as quickly as possible after a report is received.

Medical forensic examinations and biologic evidence collection shall be conducted in accordance with Georgia Bureau of Investigation (GBI) procedures using a GBI Sexual Assault Evidence Kit. It is also recommended that medical forensic exams be conducted in accordance with the *National Protocol for Sexual Assault Medical Forensic Examinations*.

A trained victim advocate will be available to accompany the patient and offer emotional support during the examination. The advocate will at no time ask the patient questions related to the details of the assault.

The SANE, physician, nurse practitioner, or PA will complete appropriate authorizations relating to the examination.

The SANE, physician, nurse practitioner, or PA will photograph and document injuries and prepare a report.

The SANE, physician, nurse practitioner, or PA will maintain and document the chain of custody of any evidence collected during the examination and assessment.

8. PROCEDURES FOR HOSPITALS RECEIVING WALK-IN REPORTS OF SEXUAL ASSAULTS

Hospitals receiving patients reporting incidents of sexual assault shall immediately contact law enforcement in accordance with O.C.G.A. § 31-7-9 mandating all non-accidental injuries be reported. Patients will retain the right not to initiate, participate in, and/or cooperate with any law enforcement investigation of such assault.

Hospital emergency department personnel shall timely notify Southern Crescent Sexual Assault and Child Advocacy Center of the incident at 770-477-2177, including which law enforcement agency is responding.

Hospital emergency department personnel shall notify the victim that the forensic medical exam will be conducted at the Southern Crescent Sexual Assault and Child Advocacy Center after the victim is medically cleared, unless the injuries are severe or other acute medical conditions exist (at which point the medical exam will be conducted in the emergency department).

9. PROSECUTION

The role of the District Attorney's office is to protect the rights of the victim while holding the offender accountable. Prosecutors should work in a collaborative fashion with law enforcement, medical forensic, and victim advocates. Prosecutors will operate under the guidelines established by *The Georgia Crime Victim's Bill of Rights* (O.C.G.A. § 17-17-1) that state, for example, that victims have the right,

- To be treated fairly and with dignity by all criminal justice agencies involved in the case
- To proceedings free from unreasonable delay
- To reasonable, accurate, and timely notice of a court proceeding where the release of the accused will be considered
- To reasonable, accurate, and timely notice of a court proceeding or any changes to such proceeding, including restitution hearings
- To reasonable, accurate, and timely notice of the accused's release and/or monitoring program
- To be present at all criminal proceedings in which the accused has a right to be present
- To NOT be excluded from any scheduled court proceedings, except as provided in O.C.G.A. § 17-17-1 or otherwise provided by law
- To a waiting area, during judicial proceedings, that is separate from the accused and his or her relatives, friends, and witnesses
- To be reasonably heard at any scheduled court proceedings involving the release, plea, or sentencing of the accused

- To complete a Victim Impact Statement and have it presented to the court prior to the trial or plea of the accused (O.C.G.A § 17-10-11)
- To refuse to submit to an interview by the accused, accused's attorney, or agent of the accused
- To a requirement by the court that defense counsel not disclose victim information to the accused (O.C.G.A. § 17-17-10)

Prosecutors and their office shall also operate under the guidelines set forth by the Georgia Constitution in Art. 1, Sec. 1, Par. XXX (Also known as *Marsy's Law*) that states that victims have the right,

- The right upon request to reasonable, accurate, and timely notice of any scheduled court proceedings involving the alleged act or changes to the scheduling of such proceedings;
- The right upon request to reasonable, accurate, and timely notice of the arrest, release, or escape of the accused;
- The right not to be excluded from any scheduled court proceedings involving the alleged act;
- The right upon request to be heard at any scheduled court proceedings involving the release, plea, or sentencing of the accused; and
- The right to be informed of his or her rights.

If a victim attends a court proceeding, a victim advocate from either Southern Crescent Sexual Assault and Child Advocacy Center or District Attorney's office will accompany the victim.

10. LOCAL SART COORDINATED RESPONSE

Members of the Clayton County SART agree to meet twice a year case for review, discussion, and evaluation to assure the coordination and cooperation between all agencies responding to sexual assault cases in Clayton County.

A. 911 RESPONSE

The first report of a sexual assault is usually made by the victim to a dispatch or

communications center of a law enforcement agency. Dispatch or communications staffers are critical in aiding the victim to regain control and composure after an assault. The staffers should remain calm, understanding, and non-judgmental while speaking with any victim. Priority ranking should be applied to all sexual assaults regardless of when the attack occurred.

If the victim is the caller, then the dispatcher should:

- Obtain the victim's name and location
- Determine where and when the attack occurred
- Determine if the victim is currently safe and whether the victim needs immediate medical attention
- Dispatch the appropriate law enforcement units and, if necessary, emergency medical help
- Emergency room staff will initiate contact with the Southern Crescent Sexual Assault Center.
- Assure the victim that help is coming
- Ask the victim to refrain from washing, bathing, showering, brushing teeth, using mouthwash, smoking, eating, drinking, douching, urinating, or defecating to prevent the loss of valuable physical evidence. **PLEASE NOTE: None of these actions prevent the ability to collect or discover potential evidence following a sexual assault. As per O.C.G.A. 17-5-72, All victims have the right to a sexual assault kit.**
- Gather other pertinent information as defined by communications agency guidelines such as the name or description of the assailant(s), the means used by the assailant(s) to leave the scene, the direction of flight, whether the suspect is a known offender or stranger, any information about the suspect's history of violence and/or use or possession of a weapon, whether drugs or alcohol were used to facilitate the sexual assault.

If it is immediately apparent to the dispatcher that the victim is unable to discuss the assault, then the dispatcher should simply seek to keep the victim calm until help arrives.

If the victim is not the caller, then the dispatcher should:

- Gather the same information previously described to assist the victim
- Enlist the help of the caller to keep the victim safe and calm until additional help arrives

A record of calls, radio traffic, and other communications pertaining to a sexual assault case may be preserved by the law enforcement agency receiving the complaint. The dispatch center may be asked to assist investigating officers by copying calls, radio traffic, and other communications received immediately after the assault.

****The following criteria are offered as guidelines, not requirements, for optimal, expeditious, and reliable responses to report sexual assault. Depending on the circumstances, there may be both a responding officer and an investigating officer, or there may only be an investigating officer. Accordingly, an investigating officer may vary the allocation of the actions described in this section.*

B. THE RESPONDING LAW ENFORCEMENT OFFICER

The first law enforcement officer to reach a sexual assault victim is usually a uniformed patrol officer. This officer, as with others who investigate the case, should quickly develop a good rapport with the victim while initiating the gathering of evidence. The responding officer in sexual assault plays a vital role in the outcome of the investigation. The responding officer has the ability to encourage the victim's participation in the criminal justice process by reassuring the victim that she/he is not being judged and that the case is taken seriously. Remembering the principles of the victim-centered approach, responding officers can investigate in a manner that helps restore a victim's sense of control. This approach builds trust and the victim's confidence in cooperating with the investigation through prosecution.

As for the immediate response, the responding officer should:

- Address the victim's physical and medical needs
- Request an ambulance if immediate medical attention is needed and an ambulance has not already been dispatched
- Address the emotional needs of the victim by remaining calm, sympathetic, and understanding
- Make contact with an advocate from the Southern Crescent Sexual Assault and Child Advocacy Center; assess advocacy needs prior to making contact to ascertain any special need such as mental/physical impairment or limited English proficiency
- Explain to the victim that a physical examination will be needed for evidence and should arrange for the transportation of the victim to the Southern Crescent Sexual Assault and Child Advocacy Center
- Ask the victim to refrain from washing, bathing, showering, brushing teeth, using mouthwash, smoking, eating, drinking, douching, urinating, or defecating to prevent the loss of valuable physical evidence. **PLEASE NOTE: None of these actions prevent the ability to collect or discover potential evidence following a sexual assault. As per O.C.G.A. 17-5-72, All victims have the right to a sexual assault kit.**
- Responding officer should not leave a victim unattended unless handling a critical threat

The responding officer, if time permits, may also ask the victim some questions about the sexual assault. Questioning should be conducted by a single officer, in the greatest

privacy available, and questioning should be limited in scope to crucial information immediately needed by law enforcement. Officers should explain that the initial interview is preliminary in nature and a follow up interview will be necessary. The follow up interview may be conducted by the same officer or by a detective if the agency has an investigative unit.

- Nature and description of assault
- Exact location and approximate time of assault
- Name or physical description of assailant(s)
- Unusual physical characteristics of assailant(s)
- Clothing of assailant(s)
- Method of flight (car, truck, on foot, etc.)
- Description of vehicle
- Direction of flight
- Name and contact information of any witnesses
- Other pertinent information as dictated by law enforcement agency
- Any weapons used in the assault or any knowledge the victim has of the suspect's history of violence or weapons possession

If the crime scene is known, the Criminal Investigation Division should be notified as soon aspossible that it will be needed to process the scene.

The responding officer will call the Southern Crescent Sexual Assault and Child Advocacy Center to request a forensic examination. The officer should remain at the facility until police investigators have arrived or until the collection of evidence is complete.

As for delayed reporting, if the victim contacts law enforcement and more than 120 hours have elapsed since the incident of sexual assault, there is a possibility that some forensic evidence may still be collected. Samples have been found up to five days later in the victim's body or there may be evidence of tearing or other internal abrasions. For this reason, the victim may be encouraged to seek medical care and to complete the medical evidence collection. All referrals should be made to the Southern Crescent Sexual Assault and Child Advocacy Center for advanced/after care services.

C. THE CRIME SCENE

No one, including the responding officer, should touch physical articles, including weapons, blood, or any other potential item of evidence at the scene. The victim's clothing and personal effects should be protected from all handling and contamination until the Crime Scene Unit reaches the crime scene. The responding officer, with the assistance of other officers, should guard the scene from any intrusion until the arrival of the Crime Scene Unit. A crime scene access log should be maintained listing the full name of every person, police and civilian, who comes to the scene. When the Crime

Scene Unit arrives at the scene, the responding officer should give them all information available regarding the crime.

D. THE INCIDENT REPORT

It is imperative that the responding officer provide an accurate and complete report detailing the officer's activity.

The report should include:

- The date and time of dispatch and arrival at the scene
- The nature of the crime
- The location of the crime
- The location of the dispatch
- A description of the crime scene (if known)
- The identity of the victim
- The victim's personal information including phone numbers and addresses for home and work
- The names, phone numbers, and addresses of any witnesses
- A description of any injuries to the victim and of the clothing of the victim and any damage to the victim's clothing or personal possessions
- A careful description of the victim's emotional state
- Actions taken on behalf of the victim
- Actions taken to preserve the crime scene
- Information learned about the sexual assault, including:
    - The exact location of the assault
    - The approximate time of the assault
    - Whether a weapon was used, and, if so, what kind
    - How the victim and assailant came to the scene
    - A description of the sexual assault
    - The identity of the assailant(s) or a complete description, including clothing and any other information obtained from the victim and witnesses
    - The means by which the assailant left the scene
    - The assailant's direction of flight
    - Any other information obtained from the victim
    - The names, addresses, and phone numbers of any witnesses identified by the victim or located by the police
    - The statements of any witnesses interviewed at the scene
    - The names of any law enforcement officers, including supervisors, detectives, and forensic officers who came to the crime scene (access log) or hospital
    - Any other actions taken in the case

- The exact time the officer left the crime scene and, if applicable, the medical facility

E. THE INVESTIGATOR'S RESPONSE

Depending on agency structure and policy, an investigator may respond to the hospital where the victim is located.

In cases where an investigator responds, the investigator should:

- Obtain a thorough briefing from the responding officer(s)
- Direct each officer who responded to the crime scene, had contact with the victim, or came to the hospital to file a detailed written report on the case
- Conduct an initial interview with the victim and write up the interview and/or audio tape it; during the initial contact, the investigator should:
  - Clearly identify himself/herself to the victim
  - Verify the information obtained by the dispatcher and/or responding officer which may help the police locate the suspect
  - Make certain that the victim understands what is being done on the victim's behalf
  - Carefully note the emotional status and physical injuries of the victim for later inclusion in the case report
  - Inform the victim that a more detailed, thorough interview will be conducted at a later time
  - Provide the victim with information or a copy of the Georgia Crime Victim's Bill of Rights

The investigator should confirm that:

- Action is being taken by other officers to locate and detain the suspect
- The crime scene, if known, is being protected and thoroughly processed by the Crime Scene Unit
- Known witnesses are being or will be interviewed
- The chain of custody is maintained, and photographs will be taken or arranged for if needed
- The emergency phone calls and records of police traffic in reference to the case are preserved by the communications department for later use
- All evidence available at the hospital, including the clothing of the victim, is collected and held by medical staff

Additionally, the investigator should:

- Consult with the victim advocate/crisis counselor and, with the consent of the victim, any family members or friends of the victim to explain the actions being taken by the police and to seek their cooperation and assistance in future contacts with the victim
- Arrange transportation home or to a safe location selected by the victim

- Assure that information about the suspect has been sent to other law enforcement agencies
- Verify that all the evidence obtained at the medical facility is correctly inventoried and prepared for transfer to the crime lab

F. DRUG FACILITATED SEXUAL ASSAULTS

In the case of suspected drug facilitated sexual assaults, law enforcement must obtain a urine sample as soon as possible. A blood sample (collected in a grey top tube) must also be collected if the assault took place within 24 hours of the sample collection. Voluntary consumption of illegal substances or underage drinking should not be used to discredit a victim or discourage participation in a criminal investigation. The investigative priority is the sexual assault, not misdemeanor violations.

G. NON-REPORTS

Non-report: As per O.C.G.A. 17-5-71 and O.C.G.A. 17-5-72, a victim shall have a right to a sexual assault kit regardless of their participation in the criminal justice process. The advocate will coordinate the sexual assault exam with the victim during the intake process. Law enforcement for the jurisdiction of the sexual assault will respond to the designated office and wait to receive the kit for storage as defined by law. Each law enforcement agency may create a report as defined by their agency policy in order to maintain for the time period defined by law.

H. PREPARATION FOR THE INTERVIEW

After a sexual assault has occurred, an in-depth interview with the victim should be conducted within 24 hours, though it may take place within a week. The victim's physical and emotional health must remain paramount, and the interview should be held when the victim is no longer in crisis.

The interview should be held in a comfortable, private setting. A location should be selected which permits both visual and sound privacy, free of unnecessary interruptions.

Victims should be given the opportunity to have a victim advocate from the Southern Crescent Sexual Assault and Child Advocacy Center present during the preliminary interview. A spouse, parent, boyfriend, or friend is not appropriate source of support for a victim during a law enforcement interview because the victim may be hesitant to reveal certain aspects of the assault in the presence of a loved one or close friend due to embarrassment on concern for the loved one's feelings. Additionally, family members, interested parties, and victim advocates should not be used as interpreters. Rather, law enforcement should refer to Southern Crescent Sexual Assault and Child Advocacy Center to obtain the best possible interpretation services for limited English proficiency or hearing-impaired victims.

The interview should be tape recorded in order to document the details of the interview, preserve the interview to permit other authorized persons to hear the victim's account without requiring additional interviews, and permit the presence of other persons, such as victim advocates, to be present at the interview.

I. THE INTERVIEW

The investigator should be professional, compassionate, understanding, and non-judgmental during the interview. The necessarily intimate communications with the victim demand tactful and sensitive questioning.

The investigator must remain aware at all times that the victim may have suffered psychological trauma far worse than any physical injury. Many victims experience a shock and anxiety which persists for hours, days, and even months after being attacked. Insensitivity to the victim can cause additional psychological harm to the victim and severely damage the investigation by diminishing the victim's willingness to cooperate with law enforcement. Conversely, a sensitive, caring investigator can bolster the victim's confidence and self-esteem and increase the victim's desire to assist with the investigation.

The investigator's role in connection with the investigation should be clearly explained to the victim. The victim should be informed why certain very intimate, perhaps embarrassing, questions must be asked, particularly about the assault itself. The victim should be assured that the investigator understands the difficulty of the interview and is more than willing to conduct the interview at a pace comfortable for the victim.

The investigator should use language that is readily understood by the victim. To the extent possible, the investigator should use the same terms, including slang, as the victim in order to build rapport with the victim and increase valuable communication. If slang terms are used, the interviewer should use the terms without hesitation or embarrassment.

Certain questions and inquiries are never appropriate. For example, victims should not be asked "did you enjoy it?" or "did you have an orgasm?"

If possible, the interview will be held when the investigator arrives with the SANE. The investigator should let the victim narrate what happened, in the victim's own words. Then follow-up questions can be asked *with the investigator explaining to the victim why those questions need to be asked*. The interview should be as thorough as possible.

Inquiry areas should include:

- The victim's prior relationship with the assailant
- Prior sexual history with the assailant
- The details of the forced sexual act(s)
- The assailant's modus operandi

- The assailant's clothing
- The assailant's appearance including marks, scars, tattoos, deformities, or unusual physical features or body odors
- The assailant's means of restraining the victim
- The victim's response to the attack, including any verbal or physical resistance
- The victim's state of mind during the attack
- The use or threat of weapons
- What the assailant said to the victim, including threats and instructions
- The names or descriptions or any other witnesses, participants, or accomplices

J. FALSE REPORTING AND RECANTATION

The definition of a false report is *the report of a sexual assault that did not happen*. It was not completed *or* attempted. A decision that an assault *did not happen* must be made based on evidence. Personal views about a victim must not influence law enforcement's investigative analysis of the evidence in a case. A suspicion of a false report is not an evidence-based reason to suspend an investigation or determine a case unfounded. If an evidence-based investigation *fails to prove* an assault occurred, the investigation would be unsubstantiated or inconclusive.

Victim Recantation is a retraction of a report of a sexual assault. Recantations are often not an indication of a false report, as victims frequently recant to avoid proceeding further with the criminal justice process. A victim may recant, even when the assault actually occurred for a variety of reasons. When a victim recants, it is incumbent upon the investigator to determine if external factors have contributed to the victim's desire to disengage from the criminal justice system. Recantations are definitely challenging, but they should not automatically result in the case being declared unfounded.

K. POST-INTERVIEW FOLLOW-UP

The investigator should encourage the victim to seek support from family, friends, and victim advocacy groups.

After the interview has been conducted, the detective should obtain any additional physical evidence, such as photos, needed from the victim. The possible need of additional steps in the investigation, including composite drawings, photographic or live line-ups, should be explained.

L. VICTIM FOLLOW-UP

During the investigation of the sexual assault, and after the arrest of an assailant, the chief investigator has a continuing responsibility to interact with the victim by:

- Informing the victim when an assailant has been arrested.
- Informing the victim of future investigative and prosecutorial activities on the case,

including those which might require the victim's involvement.

- Maintaining contact with the victim to ensure that appropriate support services are available.
- Working with prosecutors and victim advocacy agencies to develop the case and familiarize the victim with court practices and procedures

M. KIT TRACKING

Effective July 1, 2022, as per O.C.G.A 17-5-74, Sexual Assault Kits will be tracked from initial evidence collection through the investigation process. Victims are able to access the tracking system via Georgia website: https://sakts-ga.public-safety-cloud.com/. A pin number is determined and given to the victim at the time of kit completion. Each agency is required to register with the state of Georgia, complete the training, and comply as instructed.

N. THE CASE REPORT

The chief investigating officer in a sexual assault case has the crucial responsibility of compiling all the information learned throughout the investigation. This compilation, the case report, will be the main source of information for the prosecutors handling the case. Therefore, it is imperative that every effort is made to be as thorough, accurate, and informative as possible in building the report.

Appendix Q - Southern Crescent Sexual Assault and Child Advocacy Center

Acute Forensic Medical Exam Protocol

(Reported within 120 hours of the assault)

Regardless of whether the Sexual Assault has been reported to law enforcement, a forensic medical exam may be performed by a SANE (Sexual Assault Nurse Examiner). We are available to perform exams for ALL ages.
For acute cases involving children under 12 (Reported within 120 hours) or delayed disclosure (>120 hours) for ages 0-17, please **call the crisis line (770-477-2177)** to speak with an Advocate to discuss what is best for the client

1. Patrol Officer/Deputy/Investigator contacts SCSAC via the **24-Hour Crisis Line 770-477-2177.** You will either be patched through to the advocate, or they will call you back within 15 minutes.

2. Patrol Officer/Investigator relays the following information to SCSAC's Advocate, if possible:

   - Name of officer and/or investigator assigned to case
   - Name of law enforcement agency, to confirm jurisdiction
   - Gender and age of victim
   - Special needs of victim (i.e. language barriers, disabilities, etc.)
   - Time period since assault occurred
   - Location of Victim.
   - Estimated Time of Arrival at Hampton Office
   - Special needs/requests of investigator
   - Advocate will need to speak to victim
   - If the victim is a child, a custodial parent or a guardian (with documentation) must be Present to sign medical consent forms.

3. If victim goes to emergency department first, they should be medically cleared by ED staff and then released to go to the Hampton office for the rape exam.

4. If necessary, the patrol officer/deputy/investigator will remain in the building until exam and interview are completed. If the patrol officer/deputy/investigator cannot be at the office for the duration of the exam, a relief officer must be present for security purposes.

5. At the SCSAC office, the patrol officer/deputy/investigator will remain in the building until exam and interview are completed. If the patrol officer/deputy/investigator cannot

be at the office for the duration of the exam, a relied officer must be present for security purposes.

6. Law Enforcement receives all evidence (rape kit, clothing, etc.) directly from SANE or SCSAC staff.

7. Please contact SCSAC at 770/507-7772 to arrange for pick-up of medical records.

Note: If a victim is injured, highly intoxicated or potentially violent, she/he should be taken to the hospital, rather than the Hampton office.

When a sexual assault victim presents to the Emergency Department:

1. Determine jurisdiction and notify law enforcement.

2. Determine when the sexual assault occurred.

3. If the assault occurred within the last five days, notify the victim that the forensic medical exam will be conducted at the SCSAC office in Hampton after victim is medically cleared, unless victim prefers to remain in the emergency department.

4. Triage nurse will assess victim for injuries or other medical conditions.

5. If there are no injuries or in injuries are minor, the victim will be evaluated and medically cleared by an emergency department provider.

6. Medical clearance will be expedited to facilitate patient transfer to SCSAC for a forensic medical exam.

7. Forensic medical examination are provided for adult female and adult male victims.

8. If injuries or other acute medical conditions exist, the forensic medical exam will be conducted in the emergency department.

9. If patient does not have transportation, they should be transported by law enforcement.

10. **Please call the 24-hour crisis line and 770/477-2177 to let them know you are sending a caseto their Hampton office for a rape kit.**

Southern Crescent Sexual Assault and Child Advocacy Center

Office: 770/507-7772

24-hour crisis line: 770/477-2177