

SAN DIEGO COUNTY

CHILD VICTIM- WITNESS PROTOCOL

DEVELOPED AND UPDATED BY
CPT MANAGEMENT

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POLICY STATEMENT

Our Vision

Protecting children requires a united community response. Through strong collaboration among agencies and organizations, we ensure every child receives the most effective, compassionate, and culturally responsive protection and support possible.

Our Mission

The County of San Diego and its incorporated cities are committed to protecting all children—both victims and witnesses of abuse—through a coordinated, multidisciplinary team (MDT) approach. Known as the Child Protection Team (CPT), this collaboration includes law enforcement, child welfare, prosecution, mental health, medical professionals, victim advocacy, child advocacy centers (CACs), and other community partners. Together, the MDT promotes safety, healing, and justice by advancing diversity, equity, inclusion, and anti-racist practices across systems, while strengthening protective factors and ensuring compassionate, culturally responsive support for children and families.

Goals of the MDT Process and This Protocol

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

COMMUNITY PARTNERS

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

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

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

- Rady Children's Health San Diego (RCH), University of California San Diego (UCSD) and Palomar Health medical staff
- Voices for Children – Court Appointed Special Advocates (CASA) program
- City Attorney's Office (CAO) – Prosecutors and Victim Service Coordinators (VSC)
- Family Justice Centers (FJC) – The San Diego Family Justice Center – Your Safe Place [YSP (Central)]; One Safe Place [OSP (North)]; One Safe Place [OSP (South)]
- Representatives of the United States armed forces and Family Advocacy Programs (FAPs), federal law enforcement [Federal Bureau of Investigation (FBI), Department of Homeland Security (DHS), Border Patrol, etc.], probation/parole, tribal representatives, community-based trauma and mental health providers, LGBTQIA+ services, school district personnel, immigrant/refugee services, homeless services, San Diego Regional Center (SDRC)/Victim Assistance Support Team (VAST) and other disability services, San Diego Humane Society, Rancho Coastal Humane Society, etc.

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

CODE OF CONDUCT

Children's Advocacy Centers (CACs) are maintained in a manner that is physically and psychologically safe for children and families. As such, CACs are required to implement a code of conduct for staff and MDT/CPT members ensuring the safety of children and families, including relevant child abuse prevention practices. MDT members must be informed of the CAC's code of conduct and expectation that it guides work within the CAC. See appendices for more information.

Furthermore, through participation in the Annual Interagency Agreement and signing onto this protocol, MDT members assent to the penal codes, confidentiality and information sharing below.

PENAL CODES, CONFIDENTIALITY AND INFORMATION SHARING

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

Statutory Requirements for CACs

Pursuant to 2020 California Assembly Bill (AB) 2741 and Penal Code (P.C.) 11166.4, San Diego County utilizes the Chadwick Center and Palomar Health CACs to coordinate its MDT response as described in Section 18961.7 of the California Welfare and Institutions Code (WIC) to investigate reports involving child physical or sexual abuse, exploitation or maltreatment in accordance with required standards.

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

Sharing MDT Information

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

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

Furthermore, this allows Chadwick Center and Palomar Health CAC staff to openly share this information verbally and in writing (without upload into electronic medical record or recording) for continuity of care as one MDT, bound by state law and this *Child Victim-Witness Protocol*. As best practice and in alignment with legal/ethical considerations, releases of information will be obtained for more extensive consultation and/or treatment needs.

Per 2023 Senate Bill (SB) 603 [Child Abuse Privacy Protection Act (CAPPA)], California P.C. Section 11166.4(b) amendments specify additional parameters for how and when recordings of forensic interviews by CACs may be disclosed and used. Section 11166.4(b)(9) ensures that all recordings of child forensic interviews are released only in response to a court order, except they may be released without a court order to Law Enforcement agencies authorized to investigate child abuse, or other agencies authorized to prosecute juvenile or criminal conduct described in the forensic interview and/or County Counsel evaluating an allegation of child abuse.

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

Mandated Reporting Requirements

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

Sharing Investigative Information

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

Sharing Medical Information with Investigators

Health Insurance Portability and Accountability Act (HIPAA) and California law (45 CFR 164.512 and P.C. 11166) allow medical professionals and health care institutions to share otherwise protected health information with Law Enforcement and CFWB agencies engaged in the active investigation of child abuse when the child whose medical records are requested is the subject of the investigation. Once the investigation is concluded or when the information sought involves other children not the subject of the investigation, the health care

institution is prohibited from release without proper consent or a court order.

CULTURAL HUMILITY AND DIVERSITY

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

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

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

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

CAC/MDT/CPT ONBOARDING AND TRAINING

In addition to extensive agency-specific training requirements, each San Diego CAC has its own onboarding process for new CAC staff and MDT members, managed by the CAC/MDT Coordinator. The CAC/MDT Coordinator helps to develop and maintain relationships with and among MDT/CPT members, ensures adherence to MDT agreements and protocols and supports the various needs of CAC staff and MDT/CPT members through training, resourcing and evaluation.

In alignment with National Children's Alliance (NCA) accreditation requirements, both CACs regularly provide relevant training or other educational opportunities focused on issues relevant to prevention, investigation, prosecution and service provision to children and families.

Topics include, but are not limited to: understanding children's disclosure patterns; understanding the purpose and nature of medical evaluation to assist MDT members and/or CAC staff in educating children and families regarding the medical evaluation; investigative and prosecution techniques; trauma-informed/responsive care for children and families; and how to work with diverse populations (e.g. commercial sexual exploitation of children (CSEC) youth, LGBTQIA+, etc.). The CACs are responsible for documenting MDT partner participation in all CAC-sponsored trainings as part of their accreditation requirements.

MDT members and CAC staff are also trained on the diverse roles and responsibilities of each MDT member agency, their importance to the MDT collaboration and facilitating effective partnerships. Because of the emotional impact of child abuse, CACs also provide various training opportunities and resources on vicarious trauma, secondary traumatic stress (STS), compassion fatigue and building resiliency.

INVESTIGATIVE ROLES AND RESPONSIBILITIES

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

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

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

The ultimate decision to file charges and prosecute is determined by the District Attorney's (DA's) Office or the City Attorney's Office (CAO). Therefore, it is highly discouraged that the responsibility of enforcement decisions be placed on the victims of child abuse by asking them if they desire to press charges, drop charges or prosecute. The victim's and/or family's level of cooperation, along with many other factors, will be assessed by the DA's Office or CAO in their decision to do so. Questions to be considered by the Investigator include, but are not limited to:

Can the elements of the offense be established without the testimony of the victim?

- a. If yes, the case should be submitted to the District Attorney or the City Attorney for review, irrespective of the wishes of the victim.
- b. If the answer is no, the investigator must determine if the victim is generally cooperative, i.e., will they come to court if subpoenaed to do so.
 - (1) If the victim will, the case should be submitted to a prosecutor for review.
 - (2) If the victim will not, determine whether further corroboration can be obtained to allow the prosecution to proceed without a cooperative victim.
 - (3) If the answer is no and there is no independent corroboration to establish the offense, it is still recommended that the case be submitted for review.

**Suspended cases can be re-opened at any time to reinitiate the investigative process should circumstances change. Depending on the charge, the Prosecutor may be prohibited from filing charges because of the statute of limitations, but the investigation may still be re-opened and completed with new information.*

INVESTIGATIVE ROLES AND RESPONSIBILITIES (CONTINUED)

Law Enforcement (LE)	Child and Family Well-Being (CFWB)
Accept Reports - Cross Report	Accept Reports - Cross Report
	Initial face-to-face contact with child based on assigned response priority designated by the Hotline: • Within 24 hours • Within 5 days • Within 10 days
Stabilize the scene of any crime	Make initial Safety Assessment
Interview witnesses	Interview witnesses
Conduct Minimal Facts Interview (MFI), only if necessary	Conduct Minimal Facts Interview (MFI) • The only exception to this is when a Forensic Interview can be scheduled immediately and the CFWB SW can conduct the interview on other abuse types directly following the Forensic Interview.
Gather initial information – forward information to Investigator	
Assigned Investigator contacts CFWB SW and exchange contact information	Contact assigned Investigator and exchange contact information
Arrange for crime scene search and collect evidence	Photo document any relevant objects or environment and any visible injuries and alert LE
Share information relevant to the investigation with CFWB about past LE involvement with family and/or suspect or other adults living in the home • Authorize acute medical exam in sexual assault cases • Arrange Forensic Interview and/or Medical Exam. Notify CFWB SW of interview date and time.	Share information relevant to the investigation with LE about past or current CFWB involvement with family and/or suspect or other adults living in the home
Interview additional witnesses	• Interview additional collaterals and/or witnesses • Interview caregivers/parents
Gather medical information relevant to the investigation	Gather medical information relevant to the investigation
Take custody of a child if an immediate threat to their safety is present	• Complete safety assessments to determine if any safety threats are identified • Within 48 judicial hours of a hospital hold or LE entity, a petition must be filed with Juvenile Court or the child must be released to go home • Take custody of a child if an immediate threat to their safety is present and safety threats cannot be mitigated via a safety plan
Share case information relevant to the investigation	Share case information relevant to the investigation
	Make determination within 30 days of first face-to-face contact to do one of the following: • Complete risk assessments to help inform whether CFWB intervention is needed • Close without referrals to services • Close with referrals for services to community providers • Open Voluntary Services Case • File a petition with Juvenile Dependency Court (with or without removal from the home) when the safety of a child cannot be mitigated without court involvement • Court makes ruling as to whether the family is in need of Agency intervention
Arrest suspect or submit case to DA or City Attorney for review	
Submit evidence to laboratory for testing	Perform: • Ongoing Safety and Risk Assessment • Case Planning • Case Management
Interview suspects	• Safely care for children and reunify children to their families of origin • Safely support the well-being, development of permanency and lifelong relationships for children and youth • Provide ongoing case planning and delivery of service • Interview suspect(s) responsible for maltreatment

MINIMAL FACTS INTERVIEW

Best practice dictates that children who have witnessed or been victims of trauma or abuse receive a Forensic Interview (FI) and that multiple interviews of children be avoided when possible.

First Responders have to determine probable cause and whether a crime may have occurred, identify immediate protective actions, and determine next steps, which may include whether a Forensic Interview and/or Medical Exam is needed. If the first responder does not have enough information to make initial investigative and protective decisions, a Minimal Facts Interview (MFI) may be conducted. If the information needed can be obtained from other sources/evidence deemed credible by the investigating agency, the first responder should document that information and avoid a field interview of the child and refer for a forensic interview when feasible. In situations when it is necessary for first responders (LE and/or CFWB) to gather information directly from a child, coordinated efforts should be made so that one designated person conducts the MFI. This interview seeks only enough information to make immediate protective and investigative decisions. Interviewers should use the *Minimal Facts Checklist* (see *Appendix*) when interviewing children who are suspected victims or witnesses of trauma or abuse, tailoring field interview questions to the developmental age/level of the child using open-ended questions.

In situations where a Forensic Interview (FI) is needed and can be scheduled immediately, CFWB should avoid conducting a MFI if/when feasible and instead, observe the FI in-person and/or review the FI recording to gather information related to the child's statements and the allegations at hand. CFWB can then conduct a follow-up interview of the child to meet their requirement of assessing for other abuse/neglect and ensuring the overall safety/well-being of the child.

**In situations in which CFWB is unable to wait for a Forensic Interview due to internal policies, procedures and legal timelines in consultation with leadership and County Counsel, they will proceed with gathering information from all relevant parties and collaterals, including a MFI with the alleged victim child.*

FORENSIC INTERVIEW

The purpose of the Forensic Interview (FI) is to provide a safe environment for children, youth and adults with disabilities to obtain as complete and accurate a report as possible about those experiences utilizing developmentally appropriate and legally sound techniques. Information gathered in the interview assists the MDT in determining next steps and making decisions regarding criminal and protective issues, as well as assessing the child and family's needs for follow-up medical, advocacy and/or mental health services.

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

Forensic Interviewers

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

CRITERIA FOR FORENSIC INTERVIEWS

Collaboration, communication and consultation with Law Enforcement, CAC staff and CFWB Social Workers and Supervisors is of utmost importance. Generally, referrals are made by Law Enforcement if more than one agency is involved, but CFWB can also make referrals for Forensic Interviews. It is the responsibility of the referring agency to notify the other investigative agencies of the forensic interview date/time so that all investigative partners can attend and observe the FI. The referring agency coordinates the FI appointment based on CAC and family availability, but should be done as soon as reasonably possible.

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

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

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

CFWB Note: Factors to consider for Discretionary/Consultation are:

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

CRITERIA FOR FORENSIC INTERVIEWS

Allegations	Description	LE	CFWB
Sexual Abuse: Victims & Potential Victims/Witnesses* (ages 3-13)	All Sexual Abuse allegations being investigated that includes a disclosure, recantation of a disclosure and/or other evidence. <i>(For all Witnesses* categories, see definitions below chart for LE/ CFWB definitions.)</i>	Referral	Referral
Sexual Abuse: Victims & Potential Victims/Witnesses* (ages 14-17)	All Sexual Abuse allegations being investigated that includes a disclosure, recantation of a disclosure and/or other evidence. (Strongly consider <i>Referral</i> for intrafamilial and/or chronic abuse.)	Discretionary/ Consultation	Referral
CSEC: Initial Concerns (ages 3-13)	Child/youth has disclosed commercial sexual exploitation (CSE), or if child/youth does not disclose but concerns remain for the child/youth's safety and welfare (i.e. LE is involved, documented information on an incident of exploitation, chronic running away or other risk factors and reporting exploitation).	Referral	Referral
CSEC: Initial Concerns (ages 14-17)	As defined above for CSEC: Initial Concerns (ages 3-13).	Discretionary/ Consultation	Referral
CSEC: Ongoing Concerns (all ages)	As defined above for CSEC: Initial Concerns (ages 3-13).	Discretionary/ Consultation	Discretionary/ Consultation
Physical Abuse: Victims (ages 3-13)	Serious Injury as shown by: - Any act of abuse that left untreated would cause permanent physical disfigurement, permanent physical disability or death - Injuries/bruises to a non-ambulatory child - Acts of Cruelty – Torture - Bite marks without verification of witnessed non-abusive event - Burns - Strangulation (Per CFWB Family Violence Protocol, strangulation as defined by “the external compression of the neck, including the airway and blood vessels, causing reduced air and blood flow to/from the brain.”) - Fractures considered non-accidental - Injuries of unknown etiology	Referral	Referral
Physical Abuse: Witnesses* (ages 3-13) <i>Only a Referral for potential witnesses to serious injuries in non-verbal children, witness to any injuries in non-ambulatory children or conflicting stories.</i>	Serious Injury as defined above in Physical Abuse: Victims (ages 3-13).	Referral	Referral
Physical Abuse: Witnesses* (ages 14-17) <i>Potential witnesses to serious injuries in non-verbal children, witness to any injuries in non-ambulatory children or conflicting stories.</i>	Serious Injury as defined above in Physical Abuse: Victims (ages 3-13).	Discretionary/ Consultation	Referral
Physical Abuse: Victims (ages 14-17) or Witnesses* (ages 3-17) <i>When victim is verbal and there are no conflicting explanations.</i>	- Serious Injury as defined above in Physical Abuse: Victims (ages 3-13). - Minor to moderate injuries	Discretionary/ Consultation	Discretionary/ Consultation
Severe Neglect: Victims & Witnesses* (ages 3-13)	Failure to meet basic needs for food, shelter, medical care, and/or supervision, resulting in serious injury and/or near fatal conditions and/or conditions if left untreated could cause serious impairment, injury or death as shown by: - Malnutrition/Nonorganic Failure to Thrive (FTT) - Medical Neglect - Acts of Cruelty – Starvation	Referral	Referral
Severe Neglect: Victims & Witnesses* (ages 14-17)	As defined above for Severe Neglect: Victims & Witnesses (ages 3-13).	Discretionary/ Consultation	Referral
Witness* to Severe Domestic Violence/Abuse (ages 3-13)	Witness to an incident involving great bodily harm to a parent/caregiver or a caregiver causing great bodily injury to someone else (including, but not limited to: a significant or substantial physical injury and would include serious bruising or wounds, concussion, broken bones and other serious injuries).	Referral	Referral
Witness* to Severe Domestic Violence/Abuse (ages 14-17)	As defined above for Witness* to Severe Domestic Violence/Abuse (ages 3-13).	Discretionary/ Consultation	Discretionary/ Consultation
Witness* to Severe Domestic Violence/Abuse (all ages)	Strangulation, regardless of injury, as defined above for Physical Abuse: Victims (ages 3-13).	Discretionary/ Consultation	Referral
Witness* to Chronic or Serious Domestic Violence/Abuse (all ages)	When domestic violence has been ongoing, may include threats to cause great bodily injury (as defined above for Witness* to Severe Domestic Violence/Abuse (ages 3-13)), and no interview has been conducted in the past	Discretionary/ Consultation	Discretionary/ Consultation
Witness* to Violent Crime (ages 3-13)	- Homicide or Attempted Homicide - Sexual Assault - Kidnapping by non-custodial parent	Referral	N/A
Witness* to Violent Crime (ages 14-17)	As defined above for Witness to Violent Crime (ages 3-13).	Discretionary/ Consultation	N/A

Children under 3 years old or with developmental delays

*Witness for LE
*Witness for CFWB

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

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

CASE ACCEPTANCE CRITERIA FOR FORENSIC INTERVIEWS

Children, youth and adults with disabilities are interviewed in a neutral, friendly and trauma-informed environment. The process for referring alleged victims/witnesses for interviews during business hours varies slightly between Chadwick Center and Palomar Health. See *Appendix* for additional information and specific guidelines. The CACs will work with the Investigators regarding the appropriateness of a Forensic Interview based on Case Acceptance Criteria.

Criteria considerations for victims/witnesses include:

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

Other considerations:

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

Multiple/Follow Up Interviews

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

After-Hours Interviews

After-hours interviews are available as an option in urgent circumstances. Things to consider in determining urgency may include immediate safety issues to the child and/or the community at large (i.e. alleged perpetrator access); level of trauma and/or emotional state of the child; physical condition of the child; pre-school aged child with significant concerns of contamination/coaching/memory issues; flight risk; and/or in-custody in which timelines are **immediate**.

Law Enforcement and CFWB are encouraged to consult the CAC's Lead Forensic Interviewer and/or Manager to determine the best course of action in these matters.

Forensic Interview Process

Forensic Interviews are conducted at both Chadwick Center and Palomar Health Children's Advocacy Centers (CACs), with some interviews conducted by CAC staff at one of the local Family Justice Centers (FJs).

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

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

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

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

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

All interviews are digitally recorded and may only be observed by MDT members in an investigative role, including.

- Law Enforcement
- CFWB
- Community Care Licensing
- Deputy District Attorneys (DDAs) and/or DA Investigators
- Deputy City Attorneys assigned to the Criminal Division
- Tribal representatives
- Other investigative roles as agreed upon by the MDT

**Trainees approved by the MDT may also participate in an observation capacity only.*

Unauthorized observers include:

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

Access to the recording will be available to authorized agencies immediately or within 2 business days and the summary report will be provided to authorized agencies within 2 weeks of the time of service. In situations when a member of the investigative team is unable to attend the Forensic Interview (e.g., assigned after the CAC process has been initiated), the CAC will coordinate viewing of the recorded interview to avoid re-interviewing the child.

MEDICAL INTERVENTION

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

California Penal Code defines the minimum standards for the examination and treatment of sexual assault or attempted sexual assault, including child sexual abuse, and the collection and preservation of evidence. Per PC 13823.9, every public or private general acute care hospital, clinic, or other emergency medical facility that examines a victim of sexual assault or attempted sexual assault, including child sexual abuse, shall comply with the standards specified in Section 13823.11 and the protocol and guidelines adopted pursuant to Section 13823.5. California Penal Code Sections related to the performance of a medical evidentiary exam include PC 13823.93, PC 13823.5 to 13823.11, inclusive. For the purposes of this protocol, Medical Evaluation includes the medical evidentiary exam defined in California Penal Code.

Medical evaluations by Chadwick Center Child Abuse Pediatricians and/or Palomar Health Forensic Nurses are available for all children who are suspected of having been sexually abused or assaulted, regardless of ability to pay [(PC 13823.5(e)(1)); (PC 13823.5(e)(2)); ((PC 13823.95(a)); (PC 13823.95(b))]. Medical evaluations by Child Abuse Pediatricians are also available for physically abused or neglected children. The location and timing of a medical evaluation depends on case characteristics: type of abuse, timing of abuse and condition of the patient. Services can be accessed by Law Enforcement and CFWB. Written reports are generated for every medical visit and are shared with the investigative parties.

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

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

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

- Educate the child and family regarding all aspects of the medical examination and outcomes
- Provide support relative to any recommended next steps and reassurance regarding child's overall health and well-being
- Make recommendations regarding mental health and other services to address trauma related to the abuse/assault in coordination with other members of the MDT/CAC

SEXUAL ABUSE

All sexual abuse victims shall be offered the option of having a Medical Examination (information cards to be provided by the CAC). Medical Examinations may be referred by Law Enforcement, CFWB or the victim themselves (when 12 or older), free of charge. The collection of deoxyribonucleic acid (DNA) forensic evidence for the purpose of prosecution can only be authorized by Law Enforcement in the jurisdiction in which the crime occurred. Evidence gathered during the course of the medical evaluation may be used for the purposes of investigation or prosecution. As such, protected health information (PHI) can be released to investigative agencies and/or court authorities as provided by Health Insurance Portability and Accountability Act (HIPAA) § 164.512 (c)(1) & (e)(1)(i). Evidence may consist of:

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

Acute Sexual Assault Examination

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

Non-Acute Examination

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

Consent for Sexual Abuse Examinations

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

NOTE: CFWB cannot transport non-dependent children for CAC services. If and when a case is open, there is equal involvement between CFWB and LE and both are considered safe adults to transport for services. On open cases, LE and CFWB shall communicate with one another regarding the logistics of transportation to the CAC.

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

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

Pursuant to California Family Code 6926, minors 12 and older can also consent for prevention and treatment of STIs.

Parental Presence at Examination

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

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

Location of Examinations

Central, Eastern and Southern Jurisdictions:

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

Northern Jurisdictions:

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

PHYSICAL ABUSE

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

Serious or Life-Threatening Physical Abuse

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

Non-Life-Threatening Physical Abuse

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

Consent for Physical Abuse Examinations

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

Pursuant to California Family Code 6930, minors 12 and older can provide consent for their own examination as related to interpersonal violence (IPV).

Parental Presence at Examination

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

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

Location of Examinations

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

MEDICAL EXAMINATIONS CRITERIA

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

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

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

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

CFWB Note: Factors to consider for Discretionary/Consultation are:

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

MEDICAL EXAMINATIONS CRITERIA

Allegations	Description	Level of Criteria Determination
Sexual Abuse: Prepubertal female victims or biologically male victims and within ~72 hours of alleged incident or contact with the potential perpetrator <i>*See page 17 of the Protocol for additional information. Further consultation with provider at coordination of service will confirm which timeline is most appropriate based on age and physical maturation level.</i>	<i>Acute Sexual Assault Exam</i> This should occur for any disclosure of sexual abuse/assault which is being investigated. Disclosure may have been made by the victim to a professional or other evidence may be the catalyst for investigation. Other evidence may include pictures, video, presence of a Sexually Transmitted Infection (STI), a witness statement, etc.	Referral <i>NOTE: CFWB and LE can both authorize, but DNA evidence collection only occurs when LE authorizes the exam.</i>
Sexual Abuse: Postpubertal female victims within 120 hours of alleged incident of sexual abuse <i>*See page 17 of the Protocol for additional information. Further consultation with provider at coordination of service will confirm which timeline is most appropriate based on age and physical maturation level.</i>	<i>Acute Sexual Assault Exam</i> Any disclosure of sexual abuse/assault which is being investigated. Disclosure may have been made by the victim to a professional or other evidence may be the catalyst for investigation. Other evidence may include pictures, video, presence of a Sexually Transmitted Infection (STI), a witness statement, etc.	Referral <i>NOTE: CFWB and LE can both authorize, but DNA evidence collection only occurs when LE authorizes the exam.</i>
Sexual Abuse: Victims of all ages outside of the timeframes noted above	<i>Non-Acute Sexual Abuse Exam</i> Exam for children who make a disclosure of abuse to a professional or for which external evidence is present and are outside of the timeframe of an acute exam (SART). External evidence may include pictures, video, presence of a Sexually Transmitted Infection (STI), a witness statement, etc.	Referral
Sexual Abuse: Other Children in Household, all ages	Non-Acute medical exam for all children who live in the household of a confirmed victim	Referral
Sexual Abuse: Other Children Exposed to Perpetrator, all ages (NOT in same household/family)	Non-Acute medical exam for all children who have been exposed to the perpetrator and are living in the San Diego region	Referral <i>*N/A for CFWB unless there is another open investigation for that family.</i>
CSEC: Initial Concerns, all ages	Child/youth has disclosed commercial sexual exploitation (CSE), or if child/youth does not disclose but concerns remain for the child/youth's safety and welfare (i.e. LE is involved, documented information on an incident of exploitation, chronic running away or other risk factors and reporting exploitation...)	Referral
CSEC: Ongoing Concerns, all ages (Previous Exam Completed)	If concerns continue and child/youth has had an exam in the past 30 days (i.e. child disclosures to LE/CFWB/caregivers, involvement with LE, concerns for STIs, etc.) If no previous exam, follow CSEC: Initial Concerns, all ages guidelines.	Discretionary/Consultation
Physical Abuse: Victims, all ages (Current Serious Injury)	Serious Injury as shown by the following indicators: - Any act of abuse that left untreated would cause permanent physical disfigurement, permanent physical disability or death - Torture - Bite marks without verification of witnessed non-abusive event - Burns - Strangulation (Per CFWB Family Violence Protocol, strangulation as defined by "the external compression of the neck, including the airway and blood vessels, causing reduced air and blood flow to/from the brain.") - Fractures in a non-ambulatory child - Injuries/bruises to a non-mobile infant	Referral – When child currently has any of these injuries, they should receive immediate medical care if not already obtained. If you have questions, please call 858-966-8951 during business hours or by calling 858-576-1700 and asking the Operator to page the on-call Child Abuse Physician.

MEDICAL EXAMINATIONS CRITERIA (CONTINUED)

Allegations	Description	Level of Criteria Determination
<u>Physical Abuse:</u> Victims (Current Minor/Moderate Injury) - Any child under 4 years old - Developmentally delayed, non-verbal and/or non-ambulatory children	Minor/Moderate Injury includes: Bruising to the torso (abdomen, buttocks, genitals, thighs), ears, neck, frenulum (oral injury), jawline, fleshy cheeks, eyelids or bruising in the whites of the eyes	Referral
<u>Physical Abuse:</u> Victims, all ages (Current Minor/Moderate Injury)	Patterned bruising to child of any age.	Referral
<u>Physical Abuse:</u> Victims, all ages (Previous Minor/Moderate Injury that has been Photodocumented)	Minor/Moderate Injury as defined above in Physical Abuse: Victims, all ages (Current Minor/Moderate Injury).	Referral for Paper Consultation
<u>Physical Abuse:</u> Other Children in Household, all ages (Minor/Moderate Injury)	Only necessary if injuries are present or suspected for those children	Discretionary/Consultation
<u>Severe Neglect:</u> Victims, all ages	- Concerns with caregivers causing failure to meet basic needs for food, shelter and/or supervision, resulting in serious injury and/or near fatal conditions and/or conditions if left untreated could cause serious impairment, injury or death. - Starvation - Malnutrition/Nonorganic Failure to Thrive (FTT) - Medical Neglect - Exposure to drugs, excluding in utero drug exposure - Supervisional Neglect – lack of oversight by a caregiver leading to injury as noted above	Referral
<u>Severe Neglect:</u> Other Children in Household, all ages	- Starvation - Exposure to drugs, excluding voluntary intake by teenagers or in utero drug exposure	Referral (only for categories defined in this row)
<u>Severe Neglect:</u> Other Children in Household, all ages	- Concerns with caregivers causing failure to meet basic needs for food, shelter and/or supervision, resulting in serious injury and/or near fatal conditions and/or conditions if left untreated could cause serious impairment, injury or death. - Malnutrition/Nonorganic Failure to Thrive (FTT) - Medical Neglect - Supervisional Neglect – lack of oversight by a caregiver leading to injury as noted above	Discretionary/Consultation

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

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

MEDICAL EXAMINATIONS CRITERIA (CONTINUED)

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

In Person Medical Examinations	Paper Consultations
• As determined by review of the Child Abuse Pediatrician • Current injuries • Second opinion	• As determined by review of the Child Abuse Pediatrician • No current injuries • Second opinion – child previously seen by a medical professional who is not a Child Abuse Pediatrician • Medical record review for medical neglect determination • Medical record review for concerns of possible Medical Child Abuse (MCA) • Child fatality cases with concerns for possible abuse or neglect

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

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

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

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

ADVOCACY SERVICES

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

Advocates with specialized training provide a constellation of services including, but not limited to: crisis assessment and intervention, risk assessment, safety planning, support during and after interviews and/or medical exams at the CAC (as well as throughout the life of the case), assessment of individual needs and cultural considerations, assistance in procuring concrete services to meet basic needs, education and assistance on victims' rights and crime victims' compensation, provision of specialized referrals for trauma-focused and evidence-supported mental health and specialized medical treatment, transportation support, engagement with the family to help them understand the investigation/prosecution process and ensure understanding of crime victims' rights, provision of case/court updates, as well as court education, orientation and accompaniment, etc.

Advocates also participate in MDT Case Review and coordinated Case Management meetings to ensure continuity of care across programs.

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

THERAPEUTIC SUPPORT

Depending on the specific and individualized needs of the child and family, it is recommended that there is a continuum of care of therapeutic supports that are available to meet their unique needs. Therapy services are available to all CAC clients, regardless of funding. Multiple types of funding sources exist specifically to support victims of child abuse and neglect, including Victims of Crime Act (VOCA) funding through the California Office of Emergency Services (Cal-OES), as well as California Victims Compensation Board (CalVCB) Victims of Crime (VOC) funding and other grants.

Pursuant to California Family Code 6924, minors 12 and older can consent for mental health treatment and counseling services.

Crisis and Safety Support

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

Short-Term Therapeutic Intervention

Following the disclosure of abuse or neglect during a Forensic Interview and/or a Medical Exam, short-term therapeutic approaches can assist in normalizing the child and caregiver's experiences, as well as any feelings that may emerge. Short term models fill a gap between acute responses/crisis intervention and evidence-based, longer-term treatments designed to address traumatic stress symptoms and disorders that have become established. The goal is to improve the caregiver's ability to respond to, and support, a child who has endorsed symptoms. to prevent onset of post-traumatic stress disorder (PTSD). In addition, it provides an opportunity to assess which children and families need longer-term treatment.

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

An evidence-based assessment protocol should include the use multiple informants and multiple types of data collection, including the following elements to individualize treatment planning:

- A clinical interview of the child
- Interview of parents and other caregivers
- A complete developmental, medical and family history
- A comprehensive trauma history

- Use of standardized assessment measures to explore problematic behaviors and trauma symptoms
- Behavioral observations of the child and family

Children who display posttraumatic symptoms should be referred for evidence-based or evidence-informed trauma-focused treatment that promotes healing, is not forensic in nature and is most effective in treating specific symptoms.

Evidence-Based/Evidence-Informed Therapy Services

Children of all ages who have experienced trauma can benefit from evidence-based or evidence-informed therapy services. Therapy services should promote healing and not be forensic in nature. Children should receive the most effective therapy available to treat their specific symptoms. An individualized treatment plan should be developed based on assessments that are periodically reassessed.

The Therapist should be specially trained in evidence-based or evidence-informed treatment modalities (see the [California Evidence-Based Clearinghouse for Child Welfare \(CEBC\) website](#)) for child abuse victims. CFWB clients must be seen by Treatment and Evaluation Resources Management (TERM) providers. Core components of trauma-focused treatment include the following:

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

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

- Child and Family Traumatic Stress Intervention (CFTSI) [short-term model]
- Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)
- Parent-Child Interaction Therapy (PCIT)

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

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

The individualized treatment plan should be periodically reassessed and include a monitoring of trauma symptom reduction. All mental health services should be culturally informed and responsive.

Caregiver Therapeutic Services

Support from parents and/or caregivers is the most important predictor of the child's ability to make a successful recovery from the trauma. Services to parents/caregivers (i.e. relatives, foster parents, adoptive parents, etc.), who may themselves be trauma survivors and whose interactions with the Investigators and helping professionals may be influenced by their own trauma history and posttraumatic stress reactions, should be arranged and coordinated so they are best able to support and protect the child(ren). Caregiver support services should address the safety and well-being of the child and include the caregiver involvement in their child's treatment when appropriate to decrease the emotional impact of abuse on both the child(ren) and caregiver, as well as reduce the risk of future abuse.

The CACs goal is to provide trauma-informed services in the best interest of the child(ren), as well as the family, to ensure stability and healing. For caregivers that may be considered "alleged offenders" of child abuse and/or maltreatment, CAC clinical case consultation and leadership approval is required to determine the appropriateness of their presence on site at the CAC and involvement in mental health treatment. This will be determined on a case-by-case basis by each CAC. If providing mental health treatment, the CACs will add safeguards as needed and suspend or discontinue services if there are any safety concerns or other contraindicated factors that would negatively impact the child(ren) and/or treatment.

****Reminder: Alleged offenders are NOT allowed at the forensic interview and/or medical exam for current allegations or investigations.***

Additional Mental Health Activities

Mental Health Clinicians also engage in additional supportive activities, including providing referrals to other community services, regular attendance and active participation on the MDT Case Review and/or other case management meetings, serving as a Clinical Consultant regarding child trauma and evidence-based treatment, as well as supporting the MDT in monitoring treatment progress and outcomes. This includes sharing relevant information with the MDT on the child's and caregiver's engagement in, and completion of treatment, while protecting the clients' rights to confidentiality in accordance with the mental health professional's legal and ethical requirements, as well as state and federal laws. Clinicians also participate in ongoing training, clinical supervision/consultation per NCA requirements.

LEGAL REPRESENTATION

County Counsel

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

District Attorney (DA)'s Office

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

City Attorney's Office (CAO)

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

Supporting a Family through the Legal Process

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

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

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

DIVERSE POPULATIONS

Identifying Special Populations

The CACs and MDT partner agencies are committed to treating all partnerships (families and/or interagency) with respect and humility that aligns with our collective desire to be trauma responsive and ensure that families are provided with the most appropriate referrals, services and connections to local resources.

Children Exposed to Violence

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

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

Children of most ages are often able to describe a violent episode. In order to obtain the most accurate information, all children present should be interviewed separately, with special attention to the child's demeanor. These important observations assist Prosecutors in determining whether the statement will be admissible in court. Color photographs of the crime scene and evidence can corroborate the child's statement and/or demonstrate the child's exposure to violence. Even if children are not present during the reported incident, they may be instrumental in providing relevant information about a pattern and/or history of domestic violence, including physical violence, coercion and/or control. Children who have witnessed domestic violence should be considered for a forensic interview. In cases with serious charges, such as attempted murder or murder, all children living in the home should be forensically interviewed as soon as possible at Chadwick Center CAC or Palomar Health CAC.

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

Intimate Partner Violence (IPV)/Teen Dating Violence

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

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

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

Tribal

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

Commercial Sexual Exploitation of Children (CSEC)

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

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

Youth with Problematic Sexual Behaviors (YPSB)

Collaboration and coordination among agencies improves outcomes by better assessing risk and protective factors to determine the appropriate level of response for youth with problematic sexual behaviors (YPSB) cases. Effective interventions include thorough safety

assessments, coordinated case management and family-centered support. Specialized treatment focuses on the behavior and separates the behavior from the child, with special attention to language and labels. Local resources may include, but are not limited to: CAC support and consultation, [Sexual Treatment Education Prevention Services \(STEPS\)](#), Military Family Advocacy Programs (FAPs), [HOPE Program](#), etc.

Disability and Special Needs

Children, youth and adults with disabilities or special needs are at increased risk for abuse. Because of various limitations, challenges and special considerations when interviewing, all should be considered for a forensic interview by a specially trained Interviewer. Contrary to common misconceptions about people with disabilities, they are very capable of providing reliable and accurate accounts when/if interviewed correctly and by trained professionals who understand the unique needs of this population. Local resources available to those with disabilities/special needs may include, but are not limited to: [Rady Children's Hospital San Diego](#) specialty clinics [Developmental Evaluation Clinic (DEC), Developmental Screening and Enhancement Program (DSEP), Developmental Services, Developmental-Behavioral Pediatrics, Down Syndrome Center, Autism Discovery Institute, Center for Gender-Affirming Care, Cochlear Implant Program, Healthy Development Services (HDS), etc.], [San Diego Regional Center \(SDRC\)](#) and Victim Assistance and Support Team (VAST), [Deaf Community Services \(DCS\)](#), [Autism Society San Diego](#), etc.

LGBTQIA+

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

School Sexual Abuse/Assault

Sexual abuse or sexual misconduct against a student by a student or by school staff/personnel are sensitive matters that can impact the school community, as well as the community at large. These cases often present as exigent circumstances that require careful coordination between the school district, LE, CFWB (if applicable), DA's Office and CACs. Schools have an independent responsibility to investigate and respond promptly and effectively to sexual abuse suspicions and allegations as set forth in [Title IX of the Education Amendments of 1972](#). A joint, coordinated response aids in minimizing negative impact to the victim/family and the criminal investigation. *The San Diego Unified Student Sexual Abuse Response Guidelines* are in development as ancillary to this CVWP, given the intricacies involved in school sexual abuse cases and serves to facilitate interagency cooperation as each agency fulfills their respective investigative mandates.

Military and Veteran

San Diego is one of the largest military and veteran populations in the nation with 7 installations including Marine Corps Air Station Miramar, Marine Corps Base Camp Pendleton, Marine Corps Recruit Depot San Diego, Naval Base San Diego, Naval Base Coronado, Naval Base Point Loma and US Coast Guard Station San Diego. Collaboration between Family Advocacy Programs (FAPs), military criminal investigative agencies [Naval Criminal Investigative Services (NCIS); US Army Criminal Investigative Division (CID) and Department of the Air Force, Air Force Office of Special Investigations (AFOSI) with their respective Office of Special Trial Council (OSTC)] and MDT partners is essential to providing appropriate services and supports to military personnel and their families to ensure necessary prevention services, victim safety, offender accountability, rehabilitation and treatment, as well as military accountability and oversight. Both CACs have opted into the NCA Military Memorandums of Understanding (MOUs) with each branch's criminal investigative divisions and FAP programs to better support military-affiliated families in the CAC process.

Other military and veteran services may include, but are not limited to: [VA San Diego Healthcare System \(VASDHS\)](#), [Naval Medical Center San Diego](#) and [Balboa Naval Medical Center](#), [Armed Services YMCA](#), [Courage to Call](#), [Fleet and Family Support Center](#), [Military One Source](#), etc.

Federal Bureau of Investigation (FBI)

Both CACs have opted into the NCA FBI Memorandum of Understanding (MOU) to support the [FBI Violent Crimes Against Children](#) division which includes child abductions, contact offenses against children, sexual exploitation of children, trafficking of child sexual abuse material (CSAM) and international parental kidnapping. In conjunction with the FBI Child and Adolescent Forensic Interviewer (CAFI) and Victim Support Services team, the CACs can facilitate and/or support specialized services in the best interest of the child and family.

Unhoused

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

The San Diego Shelter Support Services Committee (SSSC) is a network of local organizations collaborating to support and provide resources for those struggling with housing and other co-occurring issues around San Diego County. This includes the [San Diego Humane Society](#) and [Rancho Coastal Humane Society](#), who may also be able to provide support/resources to families' pets impacted by housing uncertainty. Additionally, the [Southern California \(SoCal\) Safe Shelter Collaborative](#) rapidly connects survivors of human trafficking, DV and sexual

assault to safe shelter utilizing a robust online system to minimize barriers and delays, while emphasizing a warm handoff across providers.

Immigrant and Refugee

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

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

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

CASE REVIEW MEETINGS

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

MDT cases are primarily identified for review by mandated reports throughout RCHSD, Chadwick Center and Palomar Health CACs, as well as active cases with other MDT partners. Cases may be prioritized by those that include, but are not limited to: death due to non-accidental trauma (NAT), if other children are in the home and/or alleged perpetrator has access to other children; serious physical injuries or inpatient hospitalizations; near fatalities due to an abusive event; severe or complicated sexual abuse; STIs; chronic or high-risk Medical Child Abuse (MCA) or neglect; drug endangerment; cases involving young infants/toddlers; domestic violence concerns or another immediate safety threat in the home; strangulation; non-supportive caregivers and/or concerns for recantation; CSEC or other trafficking or concerns; repeat or multiple victim/perpetrator cases; developmental delays or disabilities; possible delays or gaps in services; differing opinions or numerous risk factors; educational component for the group; etc.

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

- Chadwick Center Child Protection Team (CPT) Case Review: The CPT meets weekly on Wednesdays from 10am-12pm at Chadwick Center and/or Zoom and is facilitated by the CAC Coordinator. The draft agenda and final agenda are distributed the week prior and contains cases selected by CAC staff and/or other MDT members. Any agency is encouraged to request a case added for review and each discipline is required to refer at least one case per month as agreed upon by the CPT Core team. Non-RCHSD employees will need to click on and follow instructions to set up a password to access the encrypted information via email.
- Palomar Health CAC Case Review: Meets on the fourth Tuesday of every month from 12-1:30pm at Palomar Health CAC at One Safe Place. The meeting agenda is distributed the week prior and contains cases selected by CAC staff and/or other MDT members that were seen between the 15th of the prior month and the 15th of the current month.

CASE TRACKING, PROGRAM DEVELOPMENT AND PROGRAM EVALUATION

Case Tracking

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

Program Development and Training

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

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

Program Evaluation and Quality Improvement

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

APPENDICIES

This section provides additional resources and supporting documentation referenced throughout this protocol.

For day-to-day application, we also suggest reviewing the [*Child Victim-Witness Protocol Orientation Guide*](#) that is updated regularly to include guidance on utilizing the CACs.

MINIMAL FACTS CHECKLIST

SAN DIEGO COUNTY CHILD PROTECTION TEAM (CPT) MINIMAL FACTS INTERVIEW (MFI) CHECKLIST

Purpose



Chadwick Center
for Children & Families



The best practice and standard of care is that children who have witnessed or been victims of trauma or abuse receive a Forensic Interview (FI) at one of the Children's Advocacy Centers (CACs), as outlined in the San Diego County Child Victim-Witness Protocol (CVWP). The goal is to minimize the number of times a child is interviewed.

First Responders' Role

First Responders have to determine probable cause and whether a crime may have occurred, identify immediate protective actions, and determine next steps, which may include whether a Forensic Interview and/or Medical Exam is needed. If the first responder does not have enough information to make initial investigative and protective decisions, a Minimal Facts Interview (MFI) may be conducted.

If the information needed can be obtained from other sources/evidence deemed credible by the investigating agency, the first responder should document that information and avoid a field interview of the child and refer for a forensic interview when feasible.



When should a MFI be done?

In situations when it is necessary for first responders (**LE and/or CFWB**) to gather information directly from a child, coordinated efforts should be made so that one designated person conducts the MFI. This interview seeks only enough information to make immediate protective and investigative decisions.

In situations where a Forensic Interview (FI) is needed and can be scheduled immediately, **CFWB** should avoid conducting a MFI if/when feasible and instead, observe the FI in-person and/or review the FI recording to gather information related to the child's statements and the allegations at hand. CFWB can then conduct a follow-up interview of the child to meet their requirement of assessing for other abuse/neglect and ensuring the overall safety/well-being of the child.

What do you need to know?



What language is child most comfortable speaking?

- What happened (basic details only)?
- Who did it (suspect)? Who saw or knew (witness)?
- Where did it happen (jurisdiction)?
- When was the last incident/contact (acute medical exam guidelines)?

Minimal Facts Field Interview

(in home, school or other location)

Agency Contacts

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

Name: _____
Phone #: _____



MINIMAL FACTS CHECKLIST CONTINUED (PG. 2)

SAN DIEGO COUNTY CHILD PROTECTION TEAM (CPT) MINIMAL FACTS INTERVIEW (MFI) CHECKLIST

Where should MFIs take place?

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

Considerations for a child victim-centered approach: minimize trauma and the number of interviews



How to question a child



Listen, be patient and use the child's own words.

Use narrative prompts, open ended questions and WH- questions as much as possible.

Examples:

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



Build rapport with child

Express interest in them as a person, not just as a victim/witness

Remain neutral, objective and supportive

Use the child's words and document child's statement as accurately as possible

Ask for basic details to make immediate protective and investigative decisions



Do not introduce new information (words, sexual acts, concepts, etc.) through words or actions

Do not summarize or paraphrase

Do not ask "yes/no" or "why" questions

Do not ask questions related to time such as "How many times?", "What time?" or "How long?"

Do not react to child's statements in ways that may minimize, blame, frighten, shame the child victim/witness

Do not make assumptions about child's perception of alleged abuse, incident or suspect

What next...? [before leaving the scene]

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

CHADWICK CENTER – FORENSIC INTERVIEW REFERRAL FORM

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

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

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



A,
+



Chadwick Forensic Interview Referral Form

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

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

Requested by

* must provide value

Do you have a Vidanyx account?

☐ Yes

☐ No

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

reset

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

* must provide value

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

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

CHADWICK CENTER CODE OF CONDUCT



Chadwick Center
for Children & Families

Chadwick Center Quick Guide: **CAC Code of Conduct**

As an accredited children's advocacy center (CAC) under [National Children's Alliance \(NCA\)](#), Chadwick Center values and prioritizes child, family and staff safety and well-being, including physical and psychological safety, which guides policy and practice decisions.

NCA's **Child Safety and Protection Standard** outlines additional requirements that CACs are required to follow, including implementing a *CAC Code of Conduct* for staff and multidisciplinary team (MDT) members, also known as the Child Protection Team (CPT), that include child abuse prevention practices.

CAC staff members must have received and agreed to the *CAC Code of Conduct*, while MDT/CPT members must be informed of it with the expectation that it guides work within the CAC.

**For the purposes of this Quick Guide, MDT/CPT partners are defined as those who utilize Chadwick Center services as outlined in our Annual Interagency Agreement, San Diego County Child Victim-Witness Protocol and/or California's Welfare & Institutions Code (WIC) § 830 related to the "...prevention, identification, management or treatment of child abuse..."*

RCHSD Policies

As a hospital-based CAC under Rady Children's Hospital – San Diego (RCHSD), all Chadwick Center staff are expected to review and adhere to all [RCHSD policies and procedures](#). While it is mandated that staff read the policies in their entirety, here's a summary of key points to reference in day-to-day CAC operations, including but not limited to:

- **EPM 12-21 Code of Conduct (Regarding Legal and Ethical Conduct)**
- **EPM 12-22 Maintaining Appropriate Boundaries**
- **HPM 4-11 Management and Reporting of Child Abuse/Neglect Cases**
- **HPM 4-29 Reporting Domestic Violence**
- **HPM 4-40 Medical Child Abuse Video Monitoring and Reporting**
- **HPM 11-79 Photography of Patients and Staff/Use of Images**

EPM 12-21 Code of Conduct (Regarding Legal and Ethical Conduct)

As one of the largest hospital-based CACs and trauma treatment centers in the nation, we provide family-focused and trauma-informed services to children and adolescents who may have experienced or witnessed maltreatment, abuse or violence. RCHSD has zero tolerance for acts of physical, verbal, sexual or emotional abuse. Staff and MDT/CPT partners are expected

CHADWICK CENTER CODE OF CONDUCT CONTINUED



Chadwick Center for Children & Families

to act in the highest ethical standards in accordance with all applicable laws, rules and regulations.

Following policy guidelines, any concerns should be addressed in alignment with **7.0 RESOLVING COMPLIANCE CONCERNS**.

EPM 12-22 Maintaining Appropriate Boundaries

Following policy guidelines, physical contact between child/client and CAC staff or MDT/CPT partners must be consistent with safety and well-being of the child/client.

The *Behavioral Expectations* section includes information on verbal and non-verbal communications, as well as special considerations, including the child's developmental stage, cultural awareness and "two sets of eyes" rule.

In addition to the expectations of EPM 12-22, Chadwick Center procedures and practice strictly prohibit contact not related to CAC service provision between staff and a child/client. All CAC staff and/or MDT/CPT interaction with child clients should be interruptible and/or observable.

HPM 4-11 Management and Reporting of Child Abuse/Neglect Cases

It is the duty of staff to report suspected child abuse in alignment with the California Child Abuse and Neglect Reporting Act (CANRA), codified at California Penal Code Sections 11164-11174.3.

Additional information can be accessed at <https://mandatedreporter.ca.com>. Mandated Reporters can also file non-emergency reports on [Child and Family Well-Being \(CFWB\)'s Online Mandated Reporter System](#) versus calling the Child Abuse Hotline at 858-560-2191.

**For Chadwick Center staff, filing through the online portal does NOT replace the need to complete a Suspected Child Abuse Report in EPIC and/or notify the appropriate law enforcement jurisdiction in which the alleged crime occurred.*

Chadwick Center Policies

The [Chadwick Center Policies and Procedures Guide](#) includes policies and guidelines created specifically for Chadwick Center programs that applicable to all Chadwick employees. It is not exhaustive. All employees are expected to follow applicable program Policies and Procedures manuals developed for their specific program.

- **A2 Child Protection Team (CPT) Meeting – Multidisciplinary Case Review**
- **A6 Psychiatric Emergencies**
- **A7 Alleged Offender and Caregiver Presence on Site**
- **C1-C8 Safety Quick Guides (All Tip Sheets)**

PALOMAR HEALTH CODE OF CONDUCT



Palomar Health Forensic Health Services Quick Guide: CAC Code of Conduct

As an accredited children's advocacy center (CAC) under [National Children's Alliance \(NCA\)](#), Palomar Health prioritizes its values of excellence, teamwork, service & safety, compassion, trust, and integrity when it comes to servicing our patients and staff. In addition to the Palomar Health Values, the CAC Code of Conduct values child safety and well-being as a primary priority and a value in the CAC that guides the department procedure and practice decisions.

NCA's *Child Safety and Protection Standard* outlines additional requirements that CACs are required to follow, including implementing a *CAC Code of Conduct* for staff and multidisciplinary team (MDT) members, also known as the Child Protection Team (CPT), that include child abuse prevention practices.

Palomar Health CAC staff members will receive a copy of the Palomar Health and the CAC Code of Conduct and agree to adhere to the Code of Conduct in the course of their CAC duties. MDT/CPT members will be informed of the Palomar Health CAC Code of Conduct with the expectation that it guides work within the CAC. The Palomar Health Code of Conduct Link and/or PDF will be available in the San Diego County CPT Orientation guide.

**For the purposes of this Quick Guide, MDT/CPT partners are defined as those who utilize Palomar Health services as outlined in our Annual Interagency Agreement, San Diego County Child Victim-Witness Protocol and/or California's Welfare & Institutions Code (WIC) § 830 related to the "...prevention, identification, management or treatment of child abuse..."*

Hospital Procedures

As a hospital-based CAC under Palomar Health – all Forensic Health and Trauma Recovery Center staff are expected to review and adhere to all [Palomar Health policies and procedures](#). While mandated that staff read the policies in their entirety, Palomar Health's *Code of Conduct* summarizes key points that are integrated into day-to-day CAC operations.

The Forensic Health Services (FHS) and Trauma Recovery Center (TRC) Department procedures provide guidelines created specifically for the programs, including the CAC. All FHS and TRC employees, consultants, and volunteers are expected to follow all policy and procedures that apply to their department.

As a hospital-based CAC and Trauma Recovery Center, we provide family-focused and trauma-informed services to children and adolescents who may have experienced or witnessed maltreatment, abuse or violence. Palomar Health has zero tolerance for acts of physical, verbal, sexual or emotional abuse. Staff and MDT/CPT partners are expected to act in the highest ethical standards in accordance with all applicable laws, rules and regulations.

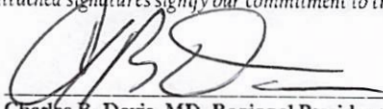


Following procedural guidelines, physical contact between child/client and CAC staff or MDT/CPT partners must be consistent with safety and well-being of the child/client. The behavioral expectations in each section in the Code of Conduct includes information on verbal and non-verbal communication, as well as special considerations, including the child's developmental stage, and cultural awareness. In addition to the expectations of the Palomar Health Code of Conduct, Palomar Health's Child Advocacy Center procedures and practices strictly prohibit contact not related to CAC service provision between staff and a child/client. All CAC staff and/or MDT/CPT interaction with child clients should be interruptible and/or observable. It is the duty of staff to report suspected child abuse.

For concerns directed to the Compliance Department at Compliance.officer@palomarhealth.org or by calling compliance hotline toll free number 1-800-850-2551. Please see Palomar Health Code of Conduct page 10 for additional reporting methods/instructions.

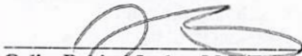
CHILD VICTIM-WITNESS PROTOCOL SIGNATURE PAGE

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



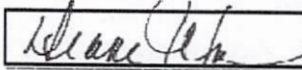
Charles B. Davis, MD, Regional President, SD County,
Rady Children's Health

7/15/26
Date



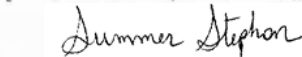
Golby Rahimi Saylor, LMFT, Executive Director, Chadwick Center
for Children & Families, Rady Children's Hospital San Diego
[CAC, Mental Health, Medical and Victim Advocacy]

7/14/26
Date



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

03/31/2026
Date



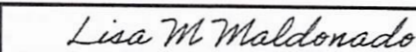
Summer Stephan, District Attorney, San Diego County

7/27/2026
Date



Heather Ferbert, San Diego City Attorney

06/02/2026
Date

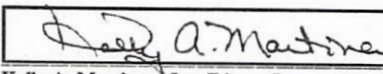


Lisa Maldonado, Chief Deputy, Office of County Counsel
Juvenile Dependency, County of San Diego

Alfredo.Guardado@sdcounty.ca.gov
Digitally signed by
Alfredo.Guardado@sdcounty.ca.gov
Date: 2026.06.07 11:15:58 -07'00'

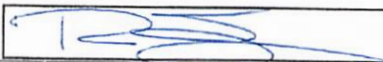
Alfredo Guardado, Director, Child and Family Well-Being (CFWB)
Department, County of San Diego

03/12/2026
Date



Kelly A. Martinez, San Diego County Sheriff

7/9/2026
Date



Chief Ray Sweeney, La Mesa Police Department
San Diego County Chiefs' and Sheriffs Association President

5-19-2026
Date

On behalf of the following law enforcement agencies:

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