

# **COUNTY OF OAKLAND**

Child Abuse & Neglect Protocol

Coordinated Investigative Team Approach

2017

## Oakland County Child Abuse and Neglect Protocol

This Protocol has been developed under MCL 722.628(6), and reflects the procedures for involving law enforcement officials in child abuse and neglect investigations. The following Protocol is consistent with the current Model Child Abuse and Neglect Protocol developed by the Governor's Task Force on Child and Abuse and Neglect.

The implementation of this Protocol reflects a commitment to the coordinated investigative team approach and replaces all previously developed Oakland County Child Abuse and Neglect Protocols.



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<sup>1</sup> A "Child Center" is a non-profit organization that provides crisis counseling, support groups, and/or child and family therapy to victims of child abuse and neglect as well as child forensic interviews.

<sup>2</sup> This protocol is limited to use in cases involving Medical Child Abuse, previously known as Munchausen by Proxy Abuse, Pediatric Condition Falsification Disorder by Proxy.

## **GLOSSARY**

CIT = Coordinated Investigative Team

CPL = Child Protection Law

CPS = Children's Protective Services

DHHS = Department of Health and Human Services

FOC = Friend of the Court

MCL = Michigan Compiled Laws

## I. STATEMENT OF PURPOSE

Responding to child abuse and neglect is a profound challenge for every community. Prosecutors, law enforcement, Child Protective Services (CPS), and other professionals recognize the special needs of child victims and are committed to working together to respond to the problem. The Child Protection Law (CPL) recognizes the need for coordinating the investigation of certain cases and requires that protocols be drafted at the local level in order to accomplish this goal.

As set forth in MCL 722.628(6):

In each county, the prosecuting attorney [Oakland County] and the department [Department of Health and Human Services] shall develop and establish procedures for involving law enforcement officials as provided in this section. In each county, the prosecuting attorney and the department shall adopt and implement standard child abuse and neglect investigation and interview protocols using as a model the protocols developed by the governor's task force on children's justice as published in FIA publication 794 (revised 8-98) and FIA Publication 779 (8-98), or an updated version of those publications.

Although coordinating an effective investigation is the goal in every case, it is only statutorily required for certain case types. The Michigan CPL (MCL 722.621 et seq.) at Section 8(3) and (4) provides (emphasis supplied):

(3) In conducting its investigation, **the department shall seek the assistance of and cooperate with law enforcement officials** within 24 hours after becoming aware that **1** or more of the following conditions exist:

(a) Abuse or neglect is the suspected cause of a child's death.

(b) The child is the victim of suspected sexual abuse or sexual exploitation.

(c) Abuse or neglect resulting in severe physical injury to the child. For purposes of this subdivision and section 17, "severe physical injury" means an injury to the child that requires medical treatment or hospitalization and that seriously impairs the child's health or physical well-being.

(d) Law enforcement intervention is necessary for the protection of the child, a department employee, or another person involved in the investigation.

(e) The alleged perpetrator of the child's injury is not a person responsible for the child's health or welfare.

(f) The child has been exposed to or had contact with methamphetamine production.

**(4) Law enforcement officials shall cooperate with the department in conducting investigations under subsections (1) and (3) and shall comply with sections 5 and 7. The department and law enforcement officials shall conduct investigations in compliance with the protocols adopted and implemented as required by subsection (6).**

## II. GOALS

The overriding philosophy of this Protocol is to consider first and foremost what is best for the child while ensuring the rights of the accused. The following goals are the basis for this Protocol:

- A. To ensure that child abuse and neglect cases are properly and effectively investigated and prosecuted.
- B. To reduce trauma and provide protection and continued support for abuse victims and their families.
- C. To improve cooperation among professionals and agencies that furthers the development of common goals and methodologies for better management of child abuse cases, including limiting the number of times a child is interviewed.
- D. To encourage open communication between all parties to resolve difficulties that may arise in the use of this Protocol.
- E. To increase awareness and reporting of child abuse and neglect cases.
- F. To ensure proper training for all professionals within the scope of this Protocol.
- G. To encourage early and continued coordination between CPS and law enforcement to make investigations more timely and inclusive.
- H. To urge consideration of the opinions and advice of all agencies involved in protecting the child.
- I. To support the video recording of investigative forensic interviews of children following the Forensic Interviewing Protocol.
- J. To encourage the establishment and utilization of child centers.

### III. GENERAL LEGAL PRINCIPLES

- A. To ensure that accurate information is received from the child and to protect the rights of the accused, the Forensic Interviewing Protocol must be utilized.
- B. More than one interview may be necessary to complete the investigation; however, all subsequent interviews must follow the Forensic Interviewing Protocol.
- C. No interview should be conducted in the presence of the perpetrator.
- D. If the county video records or audio records the interview, the procedures set forth in the Forensic Interviewing Protocol must be followed.
- E. Copies of all interviews, inculpatory or exculpatory, must be retained.
- F. When it is determined that the accused is not a "person responsible for the child's health or welfare," as defined by the CPL, CPS shall not investigate the complaint and promptly turn the case over to the appropriate law enforcement agency for investigation and disposition.
- G. Confidentiality is imposed upon both the Department of Health and Human Services (DHHS) and the law enforcement agency. While the law enforcement agency may receive information from the central registry of the DHHS, that information may only be given to another entity named in MCL 722.627 and within the limits of MCL 722.627e regarding ongoing investigations.
- H. The result of all medical, psychiatric, and psychological exams of the child (performed by specialized personnel where possible) should promptly be made available to CPS.
- I. For reported claims of abuse or neglect made against an employee of a hospital or other medical organization, a mental health agency, a school, or Friend of the Court (FOC):
  - 1. The CPL does not preclude or hinder the hospital or other medical organization, the mental health agency, the school or FOC from investigating the reported claim of abuse or neglect by its employee, provided that all other requirements imposed by law are first met.
  - 2. An internal investigation does not take precedence over the requirements of reporting to CPS or law enforcement.

3. An internal investigation should not interfere or hinder an investigation being conducted by CPS or law enforcement.
  4. An internal investigation should be coordinated with any investigation being conducted by CPS and/or law enforcement to:
    - a. Avoid duplicative interviews.
    - b. Ensure child is interviewed by a trained forensic interviewer.
    - c. Ensure proper case management.
- J. Any legally recognized privileged communication is abrogated for reporting purposes only and shall not constitute grounds for excusing a report otherwise required by law to be made. See MCL 722.631 Sec. 11 for exceptions.
- K. A notification to the person in charge of a hospital, agency or school does not relieve the reporting person of the obligation of reporting to CPS as required by law.

#### **IV. CHILD PROTECTION LAW AND ITS REQUIREMENTS**

Child abuse and child neglect are defined under the CPL at MCL 722.622. Those definitions provide as follows:

- (e) "Child" means a person under 18 years of age.
- (f) "Child abuse" means harm or threatened harm to a child's health or welfare that occurs through non-accidental physical or mental injury, sexual abuse, sexual exploitation, or maltreatment, by a parent, a legal guardian, or any other person responsible for the child's health or welfare or by a teacher, a teacher's aide, or a member of the clergy.
- G) "Child neglect" means harm or threatened harm to a child's health or welfare by a parent, legal guardian, or any other person responsible for the child's health or welfare that occurs through either of the following:
  - (i) Negligent treatment, including the failure to provide adequate food, clothing, shelter, or medical care.
  - (ii) Placing a child at an unreasonable risk to the child's health or welfare by failure of the parent, legal guardian, or other person responsible for the child's health or welfare to intervene to eliminate that risk when that person is able to do so and has, or should have, knowledge of the risk.

The CPL requires certain professionals to report child abuse or neglect to the DHHS when they have reasonable cause to suspect that a child is being abused or neglected.

Section 3(1) of the Child Protection Law sets forth (See MCL 722.623):

- (1) An individual is required to report under this act as follows:
  - (a) A physician, dentist, physician's assistant, registered dental hygienist, medical examiner, nurse, person licensed to provide emergency medical care, audiologist, psychologist, marriage and family therapist, licensed professional

counselor, social worker, licensed master's social worker, licensed bachelor's social worker, registered social service technician, social service technician, a person employed in a professional capacity in any office of the friend of the court, school administrator, school counselor or teacher, law enforcement officer, member of the clergy, or regulated child care provider who has reasonable cause to suspect child abuse or child neglect shall make an immediate report to centralized intake by telephone, or, if available, through the online reporting system, of the suspected child abuse or child neglect. Within 72 hours after making an oral report by telephone to centralized intake, the reporting person shall file a written report as required in this act. If the immediate report has been made using the online reporting system and that report includes the information required in a written report under subsection (2), that report is considered a written report for the purposes of this section and no additional written report is required. If the reporting person is a member of the staff of a hospital, agency, or school, the reporting person shall notify the person in charge of the hospital, agency, or school of his or her finding and that the report has been made, and shall make a copy of the written or electronic report available to the person in charge. A notification to the person in charge of a hospital, agency, or school does not relieve the member of the staff of the hospital, agency, or school of the obligation of reporting to the department as required by this section. One report from a hospital, agency, or school is adequate to meet the reporting requirement. A member of the staff of a hospital, agency, or school shall not be dismissed or otherwise penalized for making a report required by this act or for cooperating in an investigation.

(b) A department employee who is 1 of the following and has reasonable cause to suspect child abuse or child neglect shall make a report of suspected child abuse or child neglect to the department in the same manner as required under subdivision (a):

(i) Eligibility specialist.

- (ii) Family independence manager.
- (iii) Family independence specialist.
- (iv) Social services specialist.
- (v) Social work specialist.
- (vi) Social work specialist manager.
- (vii) Welfare services specialist.

(c) Any employee of an organization or entity that, as a result of federal funding statutes, regulations, or contracts, would be prohibited from reporting in the absence of a state mandate or court order. A person required to report under this subdivision shall report in the same manner as required under subdivision (a).

## V. COORDINATED INVESTIGATIVE TEAM APPROACH

- A. Coordinated Investigative Team (CIT)
1. Each member of the CIT should have received specialized training in the handling of abuse and neglect cases.
  2. The statute requires the following members to coordinate their efforts, and they form the central CIT:
    - a. Prosecuting Attorney - Team Leader
    - b. Children's Protective Services Investigators
    - c. Law Enforcement Investigators
  3. The CIT may include the following additional professionals, on a case-by-case basis:
    - a. Medical Personnel
    - b. Mental Health Personnel
    - c. School Personnel
    - d. Child Center Personnel
    - e. Friend of the Court Personnel
  4. Not every case will require the participation of all CIT members.
  5. The best practice is that each law enforcement agency will designate at least one officer and an appropriate backup officer, specifically identified and specially trained to handle cases of child abuse and neglect occurring within its jurisdiction.

6. All central CIT members shall be provided with a telephone contact list which shall be maintained and distributed by the team leader. This list shall be updated as necessary.

B. Coordinated Investigative Team Objective

1. Determine if the child was abused or neglected by a person responsible for the child's health or welfare and whether the child is in need of protection.
2. Determine if there is probable cause to believe a crime has been committed and, if so, who committed it.
3. Minimize trauma to the victim.
4. Ensure fairness to the accused.

C. Law Enforcement and Children's Protective Services CIT should:

1. Interview all witnesses, including but not limited to children and members of the victim's household or family.
2. Utilize the Forensic Interviewing Protocol or arrange for an interview at the CAC in all interviews of children.
3. Obtain medical treatment, when necessary.
4. Arrange for immediate medical exam when an allegation involves sexual and/or severe physical abuse which occurred in the past 120 hours. Whenever possible, the exam shall be provided by specially trained medical personnel.
5. Collect and preserve evidence.
6. Interview the alleged perpetrator.
7. Obtain family and medical histories – this may require contacting more than one physician, including family doctors and/or emergency/specially trained providers.

8. Coordinate efforts of law enforcement, with the courts, and with CPS when assistance is needed with removal of children.
9. Assess the risk of harm to any children involved in an investigation and plan a course of action with the prosecutor, law enforcement, and CPS to ensure that all children are protected.

## **VI. PROSECUTING ATTORNEY**

- A. The Prosecuting Attorney should take the leadership role with the county Child Abuse and Neglect Protocol and the CIT. This role should include:
1. Developing and implementing the county protocol.
  2. Coordinating the activities of the CIT.
  3. Reviewing the investigation of the case to ensure compliance with the county protocol where a case requires the CIT because it falls under 8(3) of the CPL.
  4. Providing legal counsel on issues relative to the investigation and prosecution of child abuse and neglect.
  5. Facilitating in-service training for local members of the CIT.
  6. Through the OCCANCO, raising awareness of the county protocol, particularly among mandatory reporters and professionals affected by the county protocol including medical providers, mental health providers, school officials, and CAC staff.
- B. The Prosecuting Attorney should pursue consistent practices for the charging, plea negotiation, and disposition of child abuse and neglect cases which achieve the following:
1. Minimize trauma to the child victim throughout all legal proceedings.
  2. Ensure the rights of the accused.
- C. The Prosecuting Attorney should enhance the advocacy of child abuse and neglect victims:
- I. By designating a person to act as the advocate for child abuse and neglect victims.

2. By accommodating the special needs of child abuse and neglect victims during their exposure to the civil and criminal justice system.
- D. If an individual is bound over to Circuit Court for criminal sexual conduct in the first, second or third degree; assault with intent to commit criminal sexual conduct; felonious attempt or felonious conspiracy to commit criminal sexual conduct; assault on a child that is punishable as a felony; child abuse in the first, second or third degree; or involvement in child sexually abusive material or activity, the Prosecuting Attorney shall execute the notices required in MCL 722.628a(2)-(5):
- (2) Employees of nonpublic school, notify governing body;
  - (3) Employees of public school districts, notify superintendent;
  - (4) Employee of a department that provides a service to children and youth as described in section 115 of the social welfare act, 1939 PA 280, MCL 400.115; notify the county director of social services or the superintendent of the training school;
  - (5) Employee of a child care provider; notify the department, the owner or operator of the child care provider's child care organization or adult foster care location authorized to care for a child, and the child care regulatory agency with authority over that child care organization or adult foster care location authorized to care for a child.

Upon final disposition of a criminal matter for which a notice was given, the Prosecuting Attorney shall notify each person previously notified of that disposition.

## VII. CHILDREN'S PROTECTIVE SERVICES

The Children's Protective Services Centralized Intake receives all initial complaints and assigns complaints to local offices for investigation.

- A. When Central Intake makes a determination that there is reasonable suspicion that a child is being neglected or abused by a person responsible for the child and that the suspected abuse complaint is covered in the CPL, they will assign the complaint to the appropriate county for investigation. Once an investigation is assigned to Oakland County CPS, the following will occur:
1. Immediately contact the law enforcement agency in the jurisdiction where abuse occurred for allegations identified in CPL Section 8(3)(a), (b), or (c) or Section 3 (6) or (9).
  2. Complete and distribute the Law Enforcement Notification Form (LEN).
    - a. To law enforcement in the jurisdiction where the abuse occurred.
    - b. To the Prosecuting Attorney.
  3. Assign a CPS investigator. The investigator will:
    - a. Initiate the investigation within the response time required by its priority.
    - b. Coordinate the investigation with law enforcement in a timely manner when a joint investigation is required.
  4. Complete the field investigation and, based on its results, determine in which single category, prescribed by Section 8d of the CPL, the allegation of abuse or neglect is categorized.
  5. Initiate a family/juvenile court action if necessary.

B. Determines that there is reasonable suspicion to believe that a child was abused by a person not responsible for the child's health or welfare and that CPS will not investigate the complaint. Following such a determination, CPS will:

1. Contact the appropriate law enforcement agency in the jurisdiction where the alleged abuse occurred.
2. Complete and distribute a complaint to the Prosecuting Attorney's Office using the LEN.

C. The CPL, MCL 722.18 Section 8(5), provides:

Involvement of law enforcement officials under this section does not relieve or prevent the department from proceeding with its investigation or treatment if there is reasonable cause to suspect that the child abuse or neglect was committed by a person responsible for the child's health or welfare.

## VIII. LAW ENFORCEMENT

- A. Each CIT law enforcement agency shall:
1. Remove a child without court order, if children are in imminent risk of harm and need emergent protection.
  2. Immediately notify Centralized Intake at 1-855-444-3911 by phone if an investigation involves suspected child abuse or neglect, and follow-up with a written DHHS-3200 form within 72 hours.
- B. In consultation and coordination with the Prosecuting Attorney and CPS, the designated CIT law enforcement member shall be responsible for:
1. The best practice with child victims of abuse is to arrange for an interview with a trained forensic interviewer<sup>3</sup> at a Child Advocacy Center that will be preserved on video recording.<sup>4</sup>
  2. Collecting and retaining evidence.
  3. Interviewing witnesses, including children.
  4. Interviewing the accused.
  5. Providing contact phone numbers for after-hours emergencies.
  6. Obtain medical treatment, if necessary.
- C. Cases of special note that prompt a specific response from the CIT
1. Methamphetamine. When a case involves a child endangered by methamphetamine, refer to Appendix D and follow that unique Protocol throughout the investigation.

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<sup>3</sup> The best practice is to have the assigned law enforcement officer and assigned CPS worker present at the **interview**.

<sup>4</sup> Child forensic interviews should be scheduled as soon as possible. CARE House (the Child Center in Oakland County) has an afterhour's emergency phone number (248-535-6777).

2. Medical Issues. When a case requires a medical evaluation of a child, refer to Section X of this Protocol.
3. Sexual Nature. When a law enforcement agency determines that the abuse of a child is of a sexual nature, it will complete all of the necessary documentation, including the state required Sex Motivated Crime Report (MSP DD-079) as required under MCL 28.246.

## IX. CHILD CENTERS

- A. A Child Center is a neutral, safe place for the child and family. It is a centralized location for the Team's initial contact with the family as well as continued team support and potential victim support services.
- B. Child Center forensic interviewers will conduct interviews of children in cases referred to the Child Center by CPS and/or law enforcement.
  - 1. Forensic interviewers will be trained in the Forensic Interviewing Protocol, in the linguistics of children, and in interviewing techniques.
  - 2. Forensic interviewers will utilize the Forensic Interviewing Protocol in all interviews of children.
  - 3. Forensic interviews will be documented pursuant to the Forensic Interviewing Protocol.
  - 4. Forensic interviews of children will be conducted in a space that is developed for children and accommodates their needs.
  - 5. Forensic interviews are essentially Team interviews as Team members will watch from another location and have an opportunity to provide input to interviewer. The intent is that a child will only be interviewed in a neutral, welcoming setting where all the members of the Team have the opportunity for input.
  - 6. Forensic interviewers must remain neutral and unbiased.
  - 7. The forensic interviewer of a child for the investigation will not participate in any follow up mental health, advocacy, or medical services in that child's case.

- C. Oakland County's Child Abuse and Neglect Collaborative Organization supports as a best practice the videorecording of investigative forensic interviews of children at Child Centers or in similar settings. If the county videorecords or audiorecords an interview, it will follow the procedures recommended in the Forensic Interviewing Protocol.<sup>5</sup>

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<sup>5</sup> Included in its entirety in the Forensic Interviewing Protocol, DHHS-PUB 779, (Appendix G), in the Videorecording Laws Appendix.

## **X. MEDICAL PERSONNEL**

- A. All medical personnel are mandated reporters under the CPL and must report when they have reasonable cause to suspect child abuse or neglect.
1. Medical Personnel follow these procedure for reporting suspected child abuse or neglect to CPS:
    - a. Identify the relationship of the alleged perpetrator of abuse and/or neglect to the child who is disclosing abuse.
    - b. Document the child's verbatim statements regarding abuse and neglect.
    - c. Immediately make a telephone referral to Centralized Intake at 1-855-444-3911.
    - d. Submit a completed DHHS-3200 form within 72 hours.
    - e. Immediately notify local law enforcement.
  2. Investigating whether actual child abuse or neglect has occurred is the responsibility of CPS and law enforcement.
- B. Medical personnel should take temporary custody of a child when release of the child to the parent or caregiver would endanger the child's health or welfare as determined by a physician. In such cases, medical personnel should:
1. Notify CPS immediately when a child is taken into medical temporary custody.
  2. Take temporary medical custody by admitting the child to the hospital with or without parental consent.
  3. Detain the child in the hospital until the next business day of the Family Division of Circuit Court.

C. Medical personnel should also do the following:

- I. Obtain a medical history from the parent, caregiver, and/or child sufficient to formulate a differential diagnosis, to plan treatment, and to ensure the safety of the child.
  - a. If possible, speak with the adult and child separately whenever possible.
  - b. Document the questions asked by medical personnel and the statements or responses by the child in the medical chart. The use of quotations is encouraged. Obtaining a medical history is subject to the following stipulations:
    1. The use of open ended questions is recommended. Avoid the use of leading questions.
    11. Investigating whether actual child abuse or neglect has occurred is the responsibility of CPS and law enforcement, and not of medical personnel reporting suspected child abuse.
      - u1. Accurate and detailed statements from the child are essential for other Team members.
      - 1v. Statements concerning abuse, when obtained for the purpose of medical diagnosis and/or treatment, are generally admissible in court.
2. Perform a physical exam to identify (or rule out) injuries to all body parts.
  - a. Complete a head to toe physical exam for suspected abuse with child undressed, including a thorough skin exam and exam of the genitals and anus. Document cutaneous skin findings.
  - b. When injuries are identified, they should be documented with photographs that identify the patient and which contain a ruler to provide scale.

- c. Photograph documentation is preferable, but the use of body diagrams of visible injuries may also be used when a camera is not available. Scale should be used.
  - d. Photo documentation of the genital and anal area is strongly encouraged in cases of suspected sexual abuse.
- 3. Collect specimens of possible DNA for analysis using the State of Michigan Forensic Evidence Kit. This should be done:
  - a. **If** the sexual assault occurred 120 hour or less before the exam.
  - b. Carefully documenting activities of child since the assault in the Sexual Assault Kit history section.
- 4. Test for Sexually-Transmitted Infection if indicated.
  - a. Testing
    - 1. Testing should be done on sites that have potentially been exposed to skin-to-skin contact as indicated by the child's statements, the perpetrator's statements, or the Team's suspicion.
    - 11. Routine testing of all children is generally not recommended. Testing should be done when supported by the appropriate history or the findings of clinical examination.
    - 111. The testing that may be necessary includes the following:
      - I. Examination to evaluate for anogenital warts and vesicular or ulcerative lesions (Herpes).

- a. Warts are generally confirmed by exam only. HPV (Human Papilloma Virus) testing can be performed if the warts need to be removed. Typing of the HPV is optional.
  - b. Suspicious lesions should be swabbed for Herpes testing by HSY (Herpes Simplex Virus) culture or PCR.
  - c. HSY Serology is strongly discouraged.
2. NAATs (Nucleic Acid Amplification Test) may be used as indicated.
  - a. In children less than 16 years old, positive NAAT testing must be confirmed prior to treatment.
  - b. Cultures of the throat, genitals and anus as indicated.
3. Chlamydia! cultures from the genitals and anus as indicated.
  - a. NAATs may be used as available.
  - b. In children less than 16 years old, positive NAAT testing must be confirmed prior to treatment.
4. Genital/urethral discharge should be tested for Trichomonas.
5. Blood testing for HIV and Syphilis as indicated by history or clinical examination.

6. Test for Hep C and Hep B as indicated.
7. Blood and/or urine testing for drugs typical of abuse and for alcohol when necessary and appropriate.
8. Blood or urine pregnancy testing with counseling for emergency contraception options offered to an adolescent patient.

b. Treatment

1. All post pubertal children may be treated prophylactically for possible sexually transmitted infections.
  11. Prepubertal children with reasonable expectation of follow-up can be seen in 14 to 21 days after acute assault, then tested and treated for any identified infections.
  111. For high risk situations where HIV prophylaxis is warranted, a referral to a pediatric infectious disease specialist should be made.
- D. The medical report should include a medical history, physical exam findings, a medical assessment and treatment recommendations.
- E. Reported claims of child abuse or neglect by an employee of a hospital or other medical organization should be referred to CPS and/or law enforcement.

## **XI. MENTAL HEALTH PERSONNEL**

- A. Mental health personnel are mandated reporters under the CPL and must report when they have reasonable cause to suspect child abuse or neglect.
  - 1. Mental health personnel shall follow these procedures for reporting suspected child abuse or neglect to CPS:
    - a. Identify the relationship of the alleged perpetrator of abuse or neglect to the child who is disclosing abuse.
    - b. Document the child's verbatim statements regarding abuse and neglect.
    - c. Immediately make a telephone referral to CPS Centralized Intake at 1-855-444-3911.
    - d. Submit a completed DHHS-3200 form within 72 hours.
  - 2. Investigating whether actual child abuse or neglect has occurred is the responsibility of CPS and law enforcement.
- B. Reported claims of child abuse or neglect by a mental health personnel should be referred to CPS/law enforcement.

## **XII. SCHOOL PERSONNEL**

- A. School administrators, school counselors and teachers or regulated child care providers are mandated reporters under the CPL and must report when they have reasonable cause to suspect child abuse or neglect:
1. School administrators, school counselors and teachers or regulated child care providers will follow these procedures for reporting suspected child abuse or neglect to CPS:
    - a. Identify the relationship to the child of alleged perpetrator of abuse or neglect to the child who is disclosing abuse.
    - b. Document the child's verbatim statements regarding abuse or neglect.
    - c. Immediately make a telephone referral to CPS Centralized Intake at 1-855-444-3911.
    - d. Submit a completed DHHS-3200 form within 72 hours.
  2. Public and private schools and other institutions shall cooperate with CPS during an investigation of reported child abuse or neglect.
  3. School administrators, school counselors and teachers should cooperate with the CIT. Cooperation includes:
    - a. Allowing access to the child without parental consent pursuant to Section 8(8) of the CPL.
    - b. Allowing CPS to interview the child alone regardless of whether law enforcement officials are present.
      1. Before contact with the child, CPS should review CPS's responsibility under Section 8(9)(a) of the CPL with the designated school staff person.

- ii. After interviewing the child, CPS should review with the designated staff member and the child the response that CPS will take, pursuant to Section 8(9)(b).
    111. CPS may share additional information with the designated staff member without the child present, pursuant to the confidentiality provisions of the CPL.
  4. Immediately after the interview, CPS should notify the person responsible for the child's health and welfare that CPS or law enforcement had contact with the child.
  5. Temporary delay in notification is permitted if the notice would compromise the safety of the child or the child's sibling(s) or the integrity of the investigation.
  6. Investigation of child abuse or neglect is the responsibility of CPS and law enforcement officials, pursuant to the CPL.
    - a. School staff, including school administrators, school counselors and teachers, is not to investigate or determine if abuse or neglect actually occurred.
    - b. No child should be subjected to a search at school that requires the child to expose buttocks, genitalia, or breasts under Section 8(8) of the CPL.
  7. Lack of cooperation by the school does not relieve or prevent CPS from proceeding with its responsibilities under the CPL.
- C. All of the CPL requirements are to be complied with regardless of any other requirements of the school.

### **XIII. FRIEND OF THE COURT PERSONNEL**

- A. Friend of the Court (FOC) personnel are mandated reporters under the CPL and must report when they have reasonable cause to suspect child abuse or neglect.
1. FOC personnel will follow the procedures for reporting suspected child abuse and neglect to CPS:
    - a. Document the child's verbatim statements regarding abuse or neglect.
    - b. Identify the relationship of the alleged perpetrator of abuse and/or neglect to the child who is disclosing abuse.
    - c. Immediately make a telephone referral to Centralized Intake at 1-855-444-3911.
    - d. Submit a completed DHHS-3200 form within 72 hours.
- C. When a judge or referee refers a case of suspected child abuse or neglect to the FOC for determination of custody and/or parenting time, the FOC will:
1. Interview the parties involved, not including children.
  2. Determine whether a DHHS-3200 report has been made to CPS.
  3. **If** a DHHS-3200 report has been made, determine the status of the investigation and whether the child has been interviewed either by CPS, law enforcement or at a CAC.
    - a. Review the child's statement if the child has been interviewed.
    - b. Contact the CIT to arrange an interview by a trained forensic interviewer if the child has not been interviewed.

4. Decide, based on the referral by the court or referee, whether an FOC investigation should be delayed pending the outcome of any CPS investigation.
5. Determine whether the child is in therapy/treatment or has been evaluated by a mental health professional regarding the allegation.
6. If a reportable disclosure of suspected child abuse or neglect is made during an investigation regarding custody/parenting time, a DHHS-3200 report must be made to CPS. See item A. in this Section.
7. Make every effort to cooperate with CPS, law enforcement and other courts or agencies to help assure the safety of children.
8. In cases in which there are conflicting criminal and family division orders, assist in coordinating information among courts, CPS and the foster care worker.
9. When a case does not involve child abuse or neglect, interview the child using interviewing techniques in accord with the Forensic Interviewing Protocol if appropriate.

# Appendix

A

**Oakland County's Child Abuse and Neglect Collaborative Organization  
Member List**

**Organization**

CARE House of Oakland County

Common Ground

Easter Seals of Southeastern Michigan

HAVEN

Michigan Department of Health and Human Services -Oakland County

Milford Police Department

Oakland County Community Mental Health Authority

Oakland County Friend of the Court

Oakland County Health Division

Oakland County Prosecuting Attorney's Office

Oakland County Sheriff's Office

Oakland Schools

William Beaumont Hospital

# Appendix

## B

## Important Phone Numbers

### **State Contact**

### **Phone Number**

DHHS Statewide Toll Free

(800) 942-4357

Poison Control Hotline

(800) 222-1222

Methamphetamine Hotline

(888) 609-6384

### **Local Contact**

Oakland County DHHS Front Desk

(248) 975-5700

Oakland County Prosecuting Attorney

(248) 858-0656

CARE House of Oakland County

(248) 333-0999

# Appendix

## C

## Law Enforcement Contact List

### **Anbrrn Hills Police Dept.**

1899N. Squirrel Rd., Auburn Hills, MI 48326  
(248) 370-9460/fax: (248) 370-9365

Chief:

Doreen E. Olko  
(248) 370-6850  
dolko@aubumhills.org

Additional Contact:

Lt. Cas Miarka  
(248) 370-6884

School Resource Officer:

Ofc. Brian Miller  
(248) 370-6880

### **Berldev Police Department**

3338 Coolidge Hwy., Berkley, MI 48072  
(248) 541-9000/fax: (248) 658-3381

### **Beverly Hills Public Safety**

18600 W. 13 Mile Rd, Beverly Hills, MI 48025  
(248) 540-3406/fax: (248) 540-3437

Chief/Supervisor:

Director Richard Torongeau  
(248) 540-3405  
rtorongeau@beverlyhillspolice.com

Additional Contact:

D/Sgt. Chad Trnssler  
(248) 540-3403  
ctrnssler@beverlyhillspolice.com

School Liaison Officer:

Lee David  
(248) 540-3406  
ldavis@beverlyhillspolice.com

**Birmingham Police Department**

151 Martin, Birmingham, MI 48009  
(248) 530-1870

Chief/Supervisor:  
Mark Clemence  
(248) 530-1875  
mclemence@bhamgov.org

Additional Contact:  
Commander Scott Grewe  
(248) 885-4651  
sgrewe@bhamgov.org

**Bloomfield Hills Public Safety Department**

45 East Long Lake Rd., Bloomfield Hills, MI 48304  
(248) 644-4200/ fax: (248) 644-0972

Chief:  
David Hendrickson  
(248) 530-1424  
dhendricksond@bloomfieldhillspolice.com

Additional Contact:  
Det/Lt. Noel Clason  
(248) 530-1425

**Bloomfield Twp. Police Department**

4200 S. Telegraph Rd., Bloomfield Hills, MI 48302  
(248) 433-7755/fax: (248) 433-7785

Chief/Supervisor:  
Geof Gaudard  
(248) 433-7751  
ggaudard@bloomfieldtwp.org

Additional Contact:  
Cpt. Scott McCanham, Investigations  
(248) 433-7766  
smccannham@bloomfieldtwp.org

Dispatch Supervisor:

Meg Fouss  
(248) 433-7659  
mfouss@bloomfieldtwp.org

Safety Liaison Officers:

Roger Wechter  
(248) 433-7769  
rwechter@bloomfieldtwp.org

David Vankerckhove  
(248) 433-7768  
dvankerckhove@bloomfieldtwp.org

**Clawson Police Department**

425 N011h Main St., Clawson, MI 48017  
(248) 435-5000/fax: (248) 435-4847

**Farmington Department of Public Safety**

23600 Liberty St., Farmington, MI 48335  
(248) 474-4700/fax: (248) 442-9815

Director:

Frank Demers  
(248) 474-5500 x2235  
fdemers@farmgov.com

Deputy Director

Ted Warthmau  
(248) 474-5500 x2238

School Liaison Officer

Alan Baranski  
(586) 212-5339  
alan.barauski@farmington.k12.mi.us

**Farmington Hills Police Department**

31655 W. 11 Mile Rd., Farmington Hills, MI 48336  
(248) 871-2610/fax: (248) 871-2770

Chief:

Charles Nebus  
(248) 871-2700  
cnebus@fhgov.com

Additional Contacts:

Lt. Jeff King, Investigative Bureau  
(248) 871-2624  
jking@fhgov.com

D/Sgt. Andy Radze  
(248) 871-2774  
aradze@fhgov.com

D/Sgt. Scott Cronin  
(248) 871-2775  
scronin@fhgov.com

School Liaison:

Det. Gary Lavin  
(248) 871-2788  
glavin@fhgov.com

School Liaison:

Det. Jeff Miller  
(248) 871-2785  
jmiller@fhgov.com

Det. Chad Double  
(248) 871-2780  
cdouble@fhgov.com

Det. Matthew Smith  
(248) 871-2783  
msmith@fhgov.com

Det. Ryan Molloy  
(248) 871-2778  
rmolloy@fhgov.com

Det. Joseph Mertes  
(248) 871-2787  
jmertes@fhgov.com

**Ferndale Police Department**

310 E. Nine Mile Rd., Ferndale, MI 48220  
(248) 546-2388/ fax: (248) 541-2836

Chief:

Timothy D. Collins  
(248) 546-2388  
tcollins@ferndalepolice.org

Additional Contacts:

Capt. Vincent Palazzolo  
vpalazzolo@ferndalepolice.org

School Resource Officer:

Janessa Danielson  
jdanielson@ferndalepolice.org

**Franklin Police Department**

32311 Franklin Rd., Franklin, MI 48025  
(248) 626-9672 or 24/7 (248) 626-54444/fax: (248) 538-5450

Chief:

Daniel D. Roberts  
(248) 626-9672  
droberts@Franklin.mi.us

Additional Contact:

D/Sgt. Mike Bastianelli  
(248) 626-9672  
bastianellim@villagepd.org

**Hazel Park Police Department**

111 E. Nine Mile Rd., Hazel Park, MI 48030  
(248) 542-6161/fax: (248) 546-4084

Chief:

Mmtin Barner  
(248) 542-6161 x-344  
mbarner@hazelparkpd.us

Additional Contact:

Det. Lt. Brian Buchholz  
(248) 542-6161 x-352  
bbuchholz@hazelparkpd.us

Youth Officer:  
Janeen Gielniak  
(248) 542-6161 x-345  
jgielniak@hazelparkpd.us

**Holly Police Department**

315 S. Broad, Holly, MI 48442  
(248) 634-8221/ fax: (248) 634-2864

Chief:  
Michael Story  
(248) 634-8221  
mstory@hollypolice.com

Additional Contact:  
Det. Wolkow  
(248) 634-8221  
hwolkow@hollypolice.com

School Liaison:  
Ofc. Mike Houck  
(248) 345-3751  
mhouck@hollypolice.com

**Huntington Woods Dept. of Public Safety**

12755 W. Eleven Mile Rd., Huntington Woods, MI 48070  
(248) 541-1180/ fax: (248) 541-3837

Chief:  
Andrew Pazuchowski  
(248) 541-1180

Additional Contact:  
Det./Deputy Chief Bill Cudney  
(248) 930-2229  
bcudney@hwmi.org

**Huron-Clinton Metroparks Police Dept.**

13000 Highridge Dr., Brighton, MI 48114  
(810) 2247-2757/ fax: (810) 227-8610

Chief:

Michael Reese  
(810) 494-6004  
michael.reese@metroparks.com

Additional Contacts:

Paula Briscoe, Police Support Specialist  
Lt. Joe Wiczorek, Administrative Lt.

**Keego Harbor Police Department**

2025 Beechmont, Keego Harbor, MI 48320  
(248) 682-3030/fax: (248) 682-1635

**Lake Angelus Police Department**

3575 Baldwin, Lake Angelus, MI 48326  
(248) 332-1220/ fax: (248) 332-1295

Chief:

James Prosser  
(248) 332-1220  
jprosser@lakeangeluspolice.org

Additional Contact:

Lt. Kevin McDaniel  
kmcdaniel@lakeangeluspolice.org

**Lake Orion Police Department**

21 E. Church St., Lake Orion, MI 48362  
(248) 693-8321/ fax: (248) 693-8941

Chief:

Jeny Narsh  
(248) 693-8323  
police@lakeorionpolice.org

Additional Contact:

Deputy Chief Lt. Harold Rossman  
(248) 693-8323  
rossmanh@lakeorionpolice.org

**Lathrup Village Police Department**

27400 Southfield Rd., Lathrup Village, MI 48076  
(248) 557-3600/fax: (248) 569-2529

**Madison Heights Police Department**

280 W. 13 Mile Rd., Madison Heights, MI 48071  
(248) 585-2100/ fax: (248) 585-9049

Chief:

Corey K. Haines  
(248) 837-2729  
coreyhaines@madison-heights.org

Additional Contacts:

Deputy Chief Timothy Pawlowski  
(248) 837-2729  
timpawlowski@madison-heights.org

Youth Ofc. Timothy First  
(248) 585-2100

**Michigan State Police, #21 Metro North**

14350 Ten Mile Rd., Oak Park, MI 48237  
(248) 584-5740/fax: (248) 584-5783

**Milford Police Department**

1100 Atlantic St., Milford, MI 48381  
(248) 684-1815/ fax: (248) 685-0543

Chief:

Thomas Lindberg  
(248) 684-1815  
tlindberg@milfordpolice.com

Additional Contact:

Lt. Matthew Brumm  
(734) 751-6101 - cell  
mbrumm@milfordpolice.com

**Northville Police Department**

215 W. Main St., Northville, MI 48167  
(248) 349-9400/ fax: (248) 349-2397

Chief:

Michael R. Carlson  
(248) 449-9921  
mcarlson@ci.northville.mi.us

Additional Contacts:

Capt. Dustin Krueger  
(248) 449-9922  
dkrueger@ci.northville.mi.us

Det. David Randall  
(248) 449-9924  
drandall@ci.northville.mi.us

**Novi Police Department**

45125 W. Ten Mile, Novi, MI 48375  
(248) 348-7100/ fax: (248) 347-0526

Chief/Director of Public Safety:

David E. Molloy  
(248) 347-0504  
dmolloy@cityofnovi.org

Additional Contact:

Uniform Operations Command  
(248) 347-0561

Emergency Dispatch  
(248) 347-0575

Det. Michael Bender - Juvenile Officer  
(248) 347-0523

Det. Jon Zabick - School Resource Officer  
(248) 347-0548

Det./Sgt. Scott Baetens - Investigations Commander  
(248) 347-0530

**Oak Park Police Department**

13800 Oak Park Blvd., Oak Park, MI 48237  
(248) 691-7520/ fax: (248) 691-7161

Director:

Steve Cooper  
(248) 691-7501  
scooper@oakparkmi.gov

Additional Contacts:

Det/Lt. Samantha Kretzschmar  
(248) 691-7511

School Liaison PSO Devin Benson  
(248) 691-7504

**Oakland Community College - Dept. of Public Safety**

2900 Featherstone Rd., Auburn Hills, MI 48326  
(248) 232-4600/ fax: (248) 232-4663

Chief/Supervisor:

Terry McCauley, Director of Public Safety, Risk Mgr.  
(248) 232-4660  
tlmccaul@oaklandcc.edu

**Oakland County Sheriff's Office**

1201 N. Telegraph Rd., Bldg., 38E, Pontiac, MI 48341  
(248) 858-4960/fax: (248) 975-9759  
Dispatch: (248) 858-4951 and (248) 858-4954

**Addison Township Substation**

1440 Rochester Rd., Leonard, MI 48367  
(248) 628-2998/fax: (248) 628-8043

**Brandon Township Substation**

15 South St., Ortonville, MI 48462  
(248) 627-4911/fax: (248) 627-1661

**Commerce Township Substation**

2401 Glengary, Commerce Township, MI 48390  
(248) 624-0715/3994/fax: (248) 960-9187

**Highland Township Substation**

165 N. John St., Highland, MI 48357  
(248) 887-6240/fax: (248) 887-5910

**Independence Township Substation**

6560 Citation Dr., Clarkston, MI 48346

(248) 620-4968/fax: (248) 620-4869

**Lyon Township Substation**

5800 Grand River, New Hudson, MI 48165

(248) 437-5600/3382/fax: (248) 446-1354

**Oakland Township Substation**

4391 Collins Rd., Rochester, MI 48306

(248) 652-4617/fax: (248) 652-2534

**Orion Township Substation**

2525 Joslyn Rd., Lake Orion, MI 48360

(248) 393-0090/fax: (248) 393-0236

**Oxford Township Substation**

2119 Lapeer Rd., Oxford, MI 48371

(248) 969-3077/0554/fax: (248) 969-8964

**Pontiac Substation**

110 E. Pike St., Pontiac, MI 48342

(248) 409-7100/fax: (248) 409-7112

**Rochester Hills Substation**

750 Barclay Circle, Rochester Hills, MI 48307

(248) 537-3530/fax: (248) 625-8613

**Springfield Township Substation**

9075 Big Lake Road, Clarkston, MI 48346

(248) 625-8531/fax: (248) 625-8613

**Oakland University Police Dept.**

201 Meadow Brook Rd., Rochester, MI 48309

(248) 370-3331/ fax: (248) 370-3043

Chief:

Mark Gordon

(248) 370-3000

mbgordon@oakland.edu

Additional Contacts:

Lt. Terry Ross, Operations Lt.  
Lt. Nicole Thompson, Operations Lt.

**Orchard Lake Police Dept.**

3955 Orchard Lake Rd., Orchard Lake, MI 48323  
(248) 682-2400/ fax: (248) 682-1308

Chief:

Joseph E. George  
(248) 682-2400  
policechief@cityoforchardlake.com

**Oxford Police Department**

22 W. Burdick, Oxford, MI 48371  
(248) 628-2581/ fax: (248) 628-7030

Chief:

Sgt. Michael Solwold  
(248) 628-2581  
solwoldm@thevillageofoxford.org

Additional Contact:

Ofc. Clint Ascroft  
(248) 628-2581

**Pleasant Ridge Police Department**

23925 Woodward Ave., Pleasant Ridge, MI 48069  
(248) 541-2900

Chief:

Kevin Nowak  
(248) 541-2900  
policechief@citvofpleasantridge.org

**Rochester Police Dept.**

400 Sixth St., Rochester, MI 48307  
(248) 651-9621/ fax: (248) 651-3607

Chief:

Steve Schettenhelm  
(248) 651-9621  
sschettenhelm@rochestermi.org

Additional Contact:

Lt. Paul Matynka  
(248) 651-9621  
pmatynka@rochestermi.org

School Liaisons:

Ofc. Amy Drehmer  
adreher@rochestemi.org

Ofc. Keith Hermans  
khermans@rochestenni.org

**Royal Oak Police Dept.**

221 E. Third St., Royal Oak, MI 48067  
(248) 246-3500/ fax: (248) 246-3401

Chief/Assistant City Manager:

Corrigan O'Donohue  
(248) 246-3525  
conigano@romi.gov

Additional Contacts:

Megan Olpere, Administrative Assistant  
(248) 246-3525  
olperem@romi.gov

Lt. Keith Spencer, Criminal Investigation Division  
(248) 246-3456  
keiths@romi.gov

Dep. Chief Mike Frazier  
(248) 246-3510  
mikef@romi.gov

Dep. Chief Bob Reilly  
(248) 246-3527  
robertr@romi.gov

Jenny Calabrese, Records Supervisor  
(248) 246-3532  
jennyc@romi.gov

**Southfield Police Department**

26000 Evergreen Rd., Southfield, MI 480076  
(248) 796-5500/ fax: (248) 796-5545

Chief:

Eric Hawkins  
(248) 796-5300  
ehawkins@cityofsouthfield.com

**South Lyon Police Department**

219 Whipple, South Lyon, MI 48178  
(248) 437-1773/ fax: (248) 437-0459

Chief:

Lloyd T. Collins  
(248) 437-04444  
chief@southlyonpolice.com

Additional Contacts:

Lt. Christopher Sovik  
(248) 437-4193

**Sylvan Lake Police Department**

1820 Iverness, Sylvan Lake, MI 48320  
(248) 682-1440/fax: (248) 682-7721

**Troy Police Department**

500 W. Big Beaver, Troy, MI 48084  
(248) 524-3477/fax (248) 524-2135

Supervisors:

Lt. Russ Harden  
(248) 619-7663  
hardemm@troymi.gov

Sgt. Robert Wolfe  
(248) 619-7687  
wolfetT@troymi.gov

Additional Contacts:

Inv. Kristine Shuler  
(248) 524-3449  
k.shuler@troymi.gov

Inv. Michael Villerot  
(248) 524-3450  
rn.villerot@troymn.gov

School Resource Officer:  
Ofc. Edwin Julian  
(248) 619-7639  
Edwin.julian@troy.rni.gov

**Walled Lake Police Department**

1499 E. West Maple Rd., Walled Lake, MI 48390  
(248) 624-3120/ fax: (248) 960-8898

Chief:  
Paul Shakinas  
(248) 624-3120 x-233  
pshaldnas@walledlake.com

Additional Contacts:  
Sgt. Anthony Delgreco  
(248) 624-3120 x-891  
adelgreco@walledlake.com

Youth/School Liaison:  
Sgt. Heather Kolke  
(248) 624-3120 x-225  
hkolke@walledlake.com

**Waterford Twp. Police Department**

5150 Civic Center Drive, Waterford, MI 48329  
(248) 674-0351/ fax: (248) 673-5190/Det. Bureau fax: (248) 674-9130

Chief:  
Scott Underwood  
(248) 618-7506  
sunderwood@waterfordrni.gov

Additional Contacts:  
D/Sgt. Brent Ross  
(248) 618-6105  
bross@waterfordmi.gov

Ofc. Dan Himmelspach  
(248) 618-6066  
dhimmelspach@waterfordmi.gov

Ofc. Dave Guida  
(248) 618-6061  
dguida@waterfordmi.gov

**West Bloomfield Police Dept.**

4530 Walnut Lake Rd., West Bloomfield, MI 48322  
(248) 975-9200/ fax: (248) 682-3992

Chief:

Mike Patton  
(248) 975-8901  
rnpatton@wbpolice.org

Additional Contacts:

Lt. Kevin Roy  
(248) 975-8931

Christina Koziarski  
(248) 975-8949

**White Lake Twp. Police Department**

7525 Highland Rd., White Lake, MI 48383  
(248) 698-4400/ fax: (248) 698-3351

Chief:

Adam Kline  
(248) 698-1042  
[akline@whitelakepolice.com](mailto:akline@whitelakepolice.com)

Additional Contacts:

Dan Keller, Lt. of Patrol  
(248) 698-4400  
dkeller@whitelakepolice.com

Larry Sheldon, Lt. of investigations  
lsheldon@whitelakepolice.com

Ross Wagenraker, Lakeland High School Liaison Officer  
rwagenraker@whitelakepolice.com

Greg Hartner, DARE/Crime Prevention Officer  
ghartner@whitelakepolice.com

**Wixom Police Department**

49045 Pontiac Trail, Wixom, MI 48393  
(248) 624-6114/ fax: (248) 624-0860

Director of Public Safety:

Charles A. Yon  
(248) 624-6114 or (248) 624-3344  
cyon@wixomgov.org

Additional Contacts:

D/Sgt. Michael Desrosiers  
(248) 624-6114  
mdesrosiers@wixomgov.org

Administrative Lt. Ronald Moore  
(248) 624-6114  
rmoore@wixomgov.org

Caroline Shave - Records Mgr./LEIN Contact  
(248) 624-6114  
cshave@wixomgov.org

**Village of Wolverine Lake Police Department**

425 Glengary, Wolverine Lake, MI 48390  
(248) 624-1335/fax: (248) 926-6065

# Appendix

## D



## DHS Methamphetamine Protocol

The DHS Methamphetamine Protocol was developed to ensure that the health and safety of children found in or near methamphetamine laboratories is addressed in a consistent and quality manner. The environmental contamination and hazardous life styles of a meth lab setting create numerous risk factors for children, and may result in abuse, neglect and/or health endangerment. This protocol addresses the immediate health and safety needs of children, establishes best practice and provides guidelines for coordinated efforts between DHS workers, law enforcement and medical services.

Methamphetamine (meth) labs can pose significant danger to all workers who conduct home visits including child welfare workers. Meth labs carry the risks of fire and explosion, exposure to chemicals and fumes, and volatile confrontations with highly agitated and unpredictable users. It is important to understand the warning signs that you may be approaching, or already in, a meth lab.

Potential indicators of meth lab activity may include but are not limited to the following:

- Strong odor of chemicals in the area.
- Large numbers of discarded propane tanks, cold medicine packages, paint thinner, antifreeze, starting fluid, Drano, Red Devil Lye, matches, lithium batteries, coffee filters, glass or plastic tubing, heating plates, and soft drink or fruit juice bottles.
- Complaints from neighbors about strange smells coming from the property.
- Heavy fortification such as bars on or blackened windows or signs of alert mechanisms such as video surveillance.
- Suspicious automobile traffic and visitors to the site.
- Unusual hours of activity.
- Chemical cans or drums in the yard.
- People leaving the building to smoke or piles of cigarette butts.
- Open windows in cold weather or fans for ventilation.

In addition to the dangers from the physical environment of a meth lab there are dangers associated with people who are abusing the drug. Some potential indicators are:

- |  |  |
|--|--|
| <ul style="list-style-type: none"><li>• Irritability and potentially violent.</li><li>• Dilated pupils.</li><li>• Paranoia.</li><li>• Agitation.</li></ul> | <ul style="list-style-type: none"><li>• Signs of chemical burns.</li><li>• Lack of dental care ("meth mouth").</li><li>• Signs of picking at skin.</li><li>• Increased feelings of depression.</li></ul> |
|--|--|

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li>• Excited speech.</li> <li>• Gaunt appearance.</li> <li>• Signs of insomnia and/or sleeping for days.</li> <li>• Inability to stay still.</li> </ul> | <ul style="list-style-type: none"> <li>• Ignoring parental duties.</li> <li>• Suicidal feelings.</li> <li>• Confusion.</li> <li>• Hallucinations .</li> <li>• Severe anxiety .</li> </ul> |
|---|---|

If a lab is alleged or encountered, child welfare workers should proceed in compliance with the following Methamphetamine Protocol:

1. When a DHS worker suspects methamphetamine manufacturing and/or components potentially hazardous to a child(ren), they should contact law enforcement. If a worker sees or smells signs of a potential meth lab, s/he must leave the property immediately without alarming the suspects and must contact law enforcement. A worker should not enter the premises of a known methamphetamine lab.
2. When law enforcement discovers evidence of current methamphetamine manufacturing and/or components potentially hazardous to a child(ren), CPS must be contacted immediately, in accordance with the Child Protection Law.
3. Coordination of the investigation with CPS and law enforcement should include:
  - Response with law enforcement in accordance with A Model Child Abuse Protocol-Coordinated Investigative Team Approach (DHS Pub. 794).
  - Identification of safety issues for any child(ren).
  - Photographs of each child and/or scene showing the proximity of the hazardous material to the child(ren)'s living environment, condition of living environment, injuries, signs of neglect, etc.
  - Identification of each child, parents and/or caretakers, other household members and witnesses.
  - Forensic interviews (refer to Forensic Interviewing Protocol, DHS Pub. 779) of each child which include questions and clarification regarding:
    - o Primary caretaker.
    - o Child's knowledge of the drug manufacturing process.
    - o Child's living area if relative to the hazardous material.
    - o Medical problems.
    - o School attendance.
    - o Other children living in the home who were not present at the time of the arrest or contact.
  - CPS and law enforcement should share information pertinent to child welfare.
4. When a child is exhibiting symptoms suspected to result from exposure to methamphetamines or components thereof, EMS must be called and an emergency medical evaluation must be sought.



# Appendix

E

## MICHIGAN DRUG ENDANGERED CHILDREN (DEC) MEDICAL PROTOCOL

This medical protocol is a guide for managing the health issues of children who are found at drug labs and/or homes. This protocol may be administered by medical, mental health, developmental and dental professionals after a child has been removed from a meth lab/home to assure the child's physical, emotional and developmental well-being.

Procedures are intended for law enforcement, child welfare, public health, emergency medical services, fire, social services and others who respond to help children found to be living in drug labs and/or homes. Due to the unique and harmful byproducts produced from cooking methamphetamine, this protocol is designed primarily for drug endangered children exposed to meth, but may also be applied to other controlled substances.

Drug Endangered Children (DEC) are children under age 18 found in homes: (a) with caregivers who are manufacturing controlled substances in/around the home, ("meth labs") or (b) where caregivers are dealing/using controlled substances and the children are exposed to the drug or drug residue ("meth homes" and/or "drug homes"). Given these circumstances, the protocol should be followed to ensure the safety, health and welfare of the child. See also related protocol, "Michigan DEC Response Protocol".

**Pursuant to P.A. 266 of 2006, DHS shall have a medical evaluation made without a court order if the child is displaying symptoms suspected to be the result of exposure to or contact with methamphetamine production.**

	Procedure Name	Timing
A	<p><b>PRELIMINARY MEDICAL ASSESSMENT</b>  <i>For child(ren) with obvious critical injury or illness, bypass this assessment and transport immediately to a medical facility capable of pediatric emergency response.</i></p> <p>The onsite assessment is done to determine whether children discovered at the scene are in need of Emergency Care (Procedure B - below). Medically trained personnel (e.g. EMT or paramedic) must do the assessment. If no medical personnel are available at the scene, the child must be taken to a medical facility for this assessment. In either case, a medical assessment should be done for child(ren) within 4 hours of discovering children at a meth home.</p> <ol style="list-style-type: none"> <li>1. Perform medical assessment consisting of:                             <ul style="list-style-type: none"> <li>• Vital signs (temperature, blood pressure, pulse, respirations)</li> <li>• Pediatric Triangle of Assessment (Airway, Breathing, Circulation)</li> </ul> </li> <li>2. Refer to procedure E of the <u>Michigan DEC Response Protocol</u> for information about removal of child's clothing, decontamination of child's skin, etc.</li> </ol> <p>If there are no obvious life threats and vital signs and initial assessment are within normal limits, the responsibility for the children should be passed to the Department of Human Services (OHS) Child Protective Services for short-term shelter or other secure placement. (See Michigan DEC <u>Response Protocol</u> Procedure H).</p> <ol style="list-style-type: none"> <li>3. No clothing (other than what the children are wearing), toys, food or drink will be removed from the home as these items are likely contaminated. If essential items such as medications, eyeglasses, etc. must be removed, place in a sealed bag. Either a Tyvek® suit or the clothing contained in the DEC kits should be placed on the child or over the children's clothing.</li> </ol>	<p>Ideal: Immediate</p> <p><u>No later than:</u>                      4 hours after removal from meth lab/home</p>
B	<p><b>EMERGENCY CARE</b> (For critical health problems only)                      The purpose of the Emergency Care evaluation is to address problems requiring care that cannot wait 4 hours to be treated as per Procedure C (Complete Evaluation and Care). Emergency care must be provided as soon as possible after significant health problems are identified in the child(ren). Emergency care must be provided by a emergency room physician or any other medical provider specializing in child abuse/neglect. If a preliminary medical assessment was not completed (Procedure A), this should be completed at the time emergency care is provided.</p>	<p>Immediately upon identification of any critical needs</p>

<ol style="list-style-type: none"> <li>1. Perform the Preliminary Medical Assessment if it was not done at the scene (follow Procedure A above).</li> <li>2. Administer tests and procedures as indicated by clinical findings.             <ul style="list-style-type: none"> <li>• A urine specimen for toxicology screening should be collected from each child. <b>Child Protective Services (CPS) or Law enforcement must identify to the Medical Provider collecting the specimen that this is a legal matter and chain of evidence procedures need to be followed</b> and request that the screen be conducted at 50 nanograms or lower and that confirmatory tests results be reported at <b>any detectable level</b>.</li> </ul> </li> <li>3. Call the Poison Center if clinically indicated (1-800-222-1222).</li> <li>4. Follow steps in Complete Evaluation (see Procedure C below) if appropriate to medical site and time permits or get assurance from DHS Child Protective Services that Complete Evaluation will be completed within 4 hours of child's removal from meth lab/home (or within 4 hours if urine has not been collected and urine screen was determined necessary by DHS and LEA).</li> <li>5. Secure the release of the child's medical records to all involved agencies, including DHS, law enforcement and prosecutor, to ensure ongoing continuity of care.</li> </ol> <p>Examine the child and direct further evaluation based upon the clinical need. Additionally, DHS should evaluate and implement placement options.</p>	
<p><b>C COMPLETE EVALUATION AND CARE</b></p> <p>A Complete Evaluation must be given by medical personnel within 4 hours of removing a child from a meth lab/home to ascertain a child's general health status. Prompt assessment is warranted due to the risk of toxicologic, neurologic, respiratory, dermatologic, or other adverse affects of methamphetamine lab chemicals and/or other drug exposure, and the high probability that the child has suffered from neglect/abuse.</p> <ol style="list-style-type: none"> <li>1. Obtain child's medical history from DHS Child Protective Services.</li> <li>2. Perform complete pediatric physical exam to include as much of the Early Periodic Screening, Detection, and Treatment (EPSDT) exam as possible. Pay particular attention to:             <ol style="list-style-type: none"> <li>a. Vital signs</li> <li>b. Neurologic screen</li> <li>c. Respiratory status</li> <li>d. Development</li> <li>e. Other signs of abuse and/or neglect</li> </ol> </li> <li>3. Call the Poison Center if clinically indicated (1-800-222-1222)</li> <li>4. Perform <b>required</b> medical evaluations:             <ol style="list-style-type: none"> <li>a. Temperature (otic, rectal, or oral)</li> <li>b. Measure and record the height and weight of child.</li> <li>c. Oxygen saturation levels</li> <li>d. Urine for toxicology. <b>CPS or Law Enforcement must identify to the Medical Provider collecting the specimen that this is a legal matter and chain of evidence procedures need to be followed.</b> Urine screens should be quantitative for level of meth (performed at 50 nanograms or lower with confirmatory results reported at <b>any detectable level</b>) and qualitative for drugs of abuse.</li> </ol> </li> </ol> <p>The following are <b>optional</b> medical evaluations that should be considered:</p> <ol style="list-style-type: none"> <li>a. Liver function tests: AST, ALT, Total Bilirubin and Alkaline Phosphatase</li> <li>b. Kidney function tests: BUN and Creatinine</li> <li>c. Electrolytes: Sodium, Potassium Chloride, and Bicarbonate</li> <li>d. Complete Blood Count (CBC)</li> <li>e. Chest x-ray (AP and lateral)</li> <li>f. Urinalysis</li> </ol>	<p>Within 4 hours of removal from meth lab/home</p>

	<ol style="list-style-type: none"> <li>5. Perform <b>optional</b> clinical evaluations as appropriate given child's condition:             <ol style="list-style-type: none"> <li>a. Complete metabolic panel (Chem 20 or equivalent)</li> <li>b. Pulmonary function tests</li> <li>c. CPK</li> <li>d. Lead level (on whole blood)</li> <li>e. Coagulation studies</li> <li>f. Carboxyhemoglobin level</li> </ol> </li> <li>6. Healthcare officials must file a report of child abuse/neglect (DHS-3200) with the DHS. Note: Per CPL 722.626 Section 6, if release to the parents would endanger the child's health or welfare, the attending physician should contact the <b>person in charge of the hospital</b>, who may detain the child in temporary protective custody for one day, or until the probate court can hear the case and make a determination.</li> <li>7. Conduct a developmental screen. This is an initial age-appropriate screen, not a full-scale assessment; may need referral to a pediatric or occupational/physical/speech specialist (OT/PT/ST). Note: If the child is between the ages of zero and three, the developmental screen may be completed by "Early On" program personnel. The DHS Child Protective Services will make an "Early On" referral. Appropriate services should be arranged for any abnormal screening results.</li> <li>8. Conduct a preliminary mental health assessment to detect any critical issues that need immediate attention. Refer for immediate mental health assessment or crisis intervention services if critical issues detected; otherwise, DHS Child Protective Services or healthcare providers may make a referral for a mental health assessment.</li> <li>9. Conduct a preliminary dental screen to detect any critical issues that need immediate attention. Refer for immediate dental services if critical issues detected; otherwise refer child for a full dental exam to be completed within 30 days.</li> <li>10. Secure the release of the child's medical records to all involved agencies, including DHS, law enforcement, and prosecutor, to ensure ongoing continuity of care. If DHS is onsite, ask Child Protection Services to complete a "release of medical information" form to facilitate this process. <i>Note: Child Protection Services personnel may not have immediate legal access to certain (historical) health care records. Every effort should be made to facilitate transfer of medical records, by providing information about where, when, and to whom records should be transferred.</i></li> <li>11. For any positive findings, follow-up with appropriate care as necessary. An appointment should be made at the time of discharge from the Emergency Room to primary care provider, preferably a pediatrician or family doctor the child already sees.</li> </ol> <p>If not already completed, placement options should be evaluated and implemented by DHS Child Protective Services.</p>	
<p><b>D</b></p>	<p><b>30 DAY FOLLOW-UP EXAM AND CARE</b></p> <p>A visit for Initial Follow-up Care occurs within 30 days of the Complete Evaluation (Procedure C) to reevaluate comprehensive health status of the child, identify any latent symptoms, and ensure appropriate and timely follow-up of services as the child's care plan and placement are established. If possible, the visit should be scheduled late in the 30-day time frame for more valid developmental and mental health results, and should include:</p> <ol style="list-style-type: none"> <li>1. Follow-up of any abnormal baseline test results.</li> <li>2. Repeat developmental screen (see Procedure C, Item 8). Communicate with the child's provider of developmental services if any abnormal results.</li> <li>3. Conduct mental health history and evaluation (requires a qualified pediatric professional).</li> <li>4. If abnormal findings on any of the above, schedule intervention and follow-up as appropriate to the findings; then proceed with Long-term Follow-up (Procedure E, below).</li> <li>5. Based on the results of these follow-up exams, the adequacy of child's shelter/placement situation should be reviewed by the DHS Child Protective Services and modified as necessary.</li> <li>6. Appropriate immunizations.</li> </ol>	<p>30 days from removal from meth lab/home</p>

<p>E</p>	<p><b>SIX AND 12 MONTH FOLLOW-UP EXAM AND CARE</b></p> <p>Long-term follow-up care is designed to 1) monitor physical, emotional, and developmental health, 2) identify possible late-developing problems related to the methamphetamine environment, and 3) provide appropriate intervention. Follow-up exams should be conducted according to the American Academy of Pediatrics recommended schedule. At minimum, a pediatric visit is required 6 and 12 months after the Complete Evaluation (Procedure C) was administered. This follow-up exam should include:</p> <ul style="list-style-type: none"> <li>a. Follow-up for previously identified problems.</li> <li>b. Perform comprehensive (EPSDT - See Procedure C, Item 2 and 8) physical exam.</li> <li>c. Repeat developmental screen (see Procedure C, Item 8). Communicate with the child's provider of developmental services if any abnormal results.</li> <li>d. Perform mental health evaluation (requires a qualified mental health professional, pediatrician, licensed therapist, child psychologist, or licensed child mental health professional).</li> </ul> <ol style="list-style-type: none"> <li>1. Plan follow-up and treatment or adjust existing treatment for any medical problems identified. Medical records should continue to accompany the child's course of care.</li> <li>2. Adequacy of child's shelter/placement situation should be reviewed by OHS Child Protective Services worker and modified as necessary.</li> <li>3. Plan follow-up strategies for developmental, mental health or placement problems identified.</li> <li>4. As needed, conduct home visits by pediatrically-trained PHN or other nurse, at 3, 9, 15, and 18 months post Complete Evaluation (Procedure C). Ensure that home visits occur between the oediatric clinic visits until the last visit at 18 months.</li> </ol>	<p>Six and 12 months from removal from meth lab/home</p>
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# Appendix

F

## MICHIGAN DRUG ENDANGERED CHILDREN (DEC) RESPONSE PROTOCOL

This response protocol is a guide for managing the safety issues of children who are found in drug labs and/or homes. Procedures are intended for law enforcement, child welfare, public health, emergency medical services, fire, social services and others who respond to help children found in drug labs and/or homes. Due to the unique and harmful byproducts produced from methamphetamine ("meth"), this protocol is designed primarily for use of meth endangered children but may also be applied to other controlled substances.

Drug Endangered Children (DEC) are children under age 18 found in homes: (a) with caregivers who are manufacturing controlled substances in/around the home ("meth Jabs") or (b) where caregivers are dealing/using controlled substances and the children are exposed to the drug or drug residue ("meth homes" and/or "drug homes"). Given these circumstances, the protocol should be followed to ensure the safety, health and welfare of the child.

A DEC response team will be managed at the local level, and should be comprised of administrators who can ensure that agency personnel are knowledgeable about the DEC protocol and that the protocol is being followed. Representation on a DEC response team should include personnel from: Prosecutor's office, law enforcement agency (LEA), Department of Human Services (DHS), school system, medical staff, and local public health.

**Pursuant to Public Act 263 of 2006, if a central registry case involves a child's exposure to or contact with methamphetamine production, the DHS shall refer the case to the prosecuting attorney for the county in which the child is located.**

### **A. INITIAL DISCOVERY: RESPONSE TO CHILDREN FOUND IN A DRUG HOME**

***Appropriate Responder: LEA, OHS, and if LEA gives clearance, additional responders***

1. Any responder who discovers children living in a home where meth or other drugs are being used, dealt and/or manufactured and where the children are exposed to the drug or drug residue will contact LEA (call 9-1-1) and Department of Human Services (DHS) and request dispatch to the scene.
2. Pursuant to P.A. 256 of 2006, in conducting an investigation of child abuse involving a child's exposure to or contact with methamphetamine production, DHS shall seek the assistance of and cooperate with law enforcement officials within 24 hours of initial discovery. Law enforcement officials shall cooperate with DHS in conducting investigations of child abuse related to methamphetamine exposure or contact.
3. If while in the home, any responder other than LEA sees or smells any signs of a potential meth lab or evidence of other narcotic use, he/she will exit immediately without alarming the suspects and contact LEA.
4. Other responders may only enter a drug home if it has been secured and determined safe by LEA. Other responders will work under the direction of LEA to assist in removing children, and if directed to do so, their belongings, from the home.

### **B. INITIAL DISCOVERY: RESPONSE TO CHILDREN FOUND AT METH LABS**

***Appropriate Responder: Law Enforcement Authority (LEA)***

For the purposes of this protocol, a meth lab is considered any location where chemicals and/or equipment used to make methamphetamine are present.

1. Only Occupational Safety and Health Administration (OSHA)-certified LEA will enter a known meth lab. Any other responders who are in a home and begin to have suspicions that a meth lab is present will exit immediately without alarming the suspects; contact LEA (call 9-1-1); request immediate dispatch; and give details about the scene (weapons, odors, number of people inside, chemicals, equipment, etc.).
2. No one other than OSHA-certified LEA will remove adults/children from a home that contains a meth lab. This is for the safety of everyone involved; uncertified responders may inadvertently set off an explosion. The chemicals used to make meth are highly volatile. Labs are often guarded by firearms, traps, explosives and other hazards.
3. If a child protective services worker is not already on the scene, responders shall contact DHS and request immediate dispatch, state that children have been found at a meth lab and if possible, state the names and dates of birth.
4. LEA will enter the lab wearing appropriate safety gear (Refer to OSHA Standards 1910.132-137 (Personal Protective Equipment)); secure the scene; and remove adults and children from home.
5. No clothing (other than what the children are wearing), toys, food or drink will be removed from the home as these items are likely contaminated. Either a Tyvek® suit or the clothing contained in the DEC kits should be placed on the child or over the children's clothing. If essential items such as medications, eyeglasses, etc. must be removed, place in a sealed bag.

<p><b>C. PRELIMINARY MEDICAL ASSESSMENT OF CHILDREN</b> <i>Appropriate Responder: DHS and Medical personnel</i> Pursuant to P.A. 266 of 2006, OHS shall have a medical evaluation made without a court order if the child is displaying symptoms suspected to be the result of exposure to or contact with methamphetamine production.</p> <p>DHS, and in their absence the LEA, will ensure that medically-trained personnel conduct an initial assessment as soon as possible (within 4 hours) upon discovery of children at meth lab/home. If children are in need of emergency care please refer to letter D, below. <u>(Refer to Michigan DEC Medical Care Protocol).</u></p>
<p><b>D. EMERGENCY TRANSPORT OF CHILDREN TO MEDICAL FACILITY</b> <i>Appropriate Responder: Emergency Medical Services (EMS)</i> If children have critical injuries, illness, or severe emotional trauma, transport to the Emergency Room (ER) immediately. If children were removed from a <i>meth lab</i>, call prior to arrival, alert of possible chemical contamination and follow ER procedures.</p>
<p><b>E. PHOTOGRAPHING AND DECONTAMINATION OF CHILDREN REMOVED FROM METH LAB/HOME</b> <i>Appropriate Responder: LEA *Note: DHS may be on the scene to assist LEA with children.</i> Special consideration should be given to who assists children with the decontamination process. A child may be uncomfortable being undressed by someone of the opposite sex or someone other than a medical professional.</p> <ol style="list-style-type: none"><li>1. If possible, photograph and decontaminate the children (remove chemical residue) <i>at the scene</i> by taking the children to a safe location that affords privacy and by doing the following: Wear nitrile gloves; photograph children in original clothing to document condition of child; photograph any visible injuries; dress in disposable Tyvek® suit or clean clothing provided by a responder; follow LEA procedure for disposal of contaminated gloves, and clothing.</li><li>2. If not possible to decontaminate at the scene, protect responders and response vehicles from chemical residue on child prior to transport by doing the following: Wear nitrile gloves; leave child in existing clothing; wrap child in a disposable emergency blanket or a thick blanket; or put oversized coat/sweat suit over child's clothing; and follow LEA procedure for disposal of contaminated gloves.</li></ol>
<p><b>F. OBTAINING URINE SAMPLE FROM CHILDREN WITHIN 4 (FOUR) HOURS</b> <i>Appropriate Responder: Medical Personnel</i> A urine sample should be collected from all children who are removed from <i>meth labs</i>. For children removed from <i>meth homes</i> (where meth was being used or dealt but not manufactured), DHS should collaborate with LEA and medical personnel to determine whether a urine screen should occur, based on the likelihood of exposure, weighing such factors as the child's access to the drugs. Any urine samples must be collected within 4 hours of the child's removal to yield the most accurate results (for medical analysis and for evidence for prosecuting child endangerment). Consideration should be given to the age and sex of the child when determining who will monitor (and assist, if necessary) the child during this process.</p> <p><i>Note: If possible, order a urine screen that will test for presence of meth or other controlled substances at any detectable level (performed at 50 nanograms or lower. Do not use NINA thresholds for screening purposes).</i></p>
<p><b>G. FORENSIC INTERVIEW OF CHILDREN</b> <i>Appropriate Responder: DHS responsibility in conjunction with LEA to ensure that appropriately trained personnel conduct forensic interview per DHS protocol.</i> The purpose of this brief interview is to determine the children's primary caregiver, the kind of care the children are receiving and the degree of access children have had to the meth lab and/or drugs.</p> <ol style="list-style-type: none"><li>1. If possible, given specific circumstances, conduct forensic interview of child at the scene to ascertain:<ol style="list-style-type: none"><li>a. Last meal eaten and who prepared it</li><li>b. Last bathing and by whom</li><li>c. How child feels physically and mentally</li><li>d. Child aware if anyone in home smokes? If yes, what do they smoke?</li><li>e. Anything in house that bothers the child?</li><li>f. Other siblings living in the house who aren't home right now?</li></ol></li><li>2. A second forensic interview in a child-friendly setting should occur within 48 hours of discovery of children within a drug endangered environment.</li></ol>
<p><b>H. REMOVAL AND PLACEMENT OF CHILDREN</b> <i>Appropriate Responder: DHS and/or LEA</i> When DHS finds that a child within a drug home is at an imminent risk of harm or threatened harm and it is contrary of the welfare of the child to remain in the home, DHS must intervene on behalf of these children and determine the appropriate action and/or Placement, per DHS policy.</p>

**Pursuant to Public Act 256 of 2006, within 24 hours after DHS determines that a child was allowed to be exposed to or have contact with methamphetamine production, DHS shall submit a petition for authorization by the court under MCL 712A.2.**

If OHS is unable to respond to the scene, any available responder should contact a local OHS office to report the drug endangered child. Other responders should not release children to neighbors, relatives, etc.

1. If OHS is seeking removal, OHS will contact the court to obtain an order for out-of-home placement.
2. OHS will obtain children's birth and medical information from caregivers and serve notice of preliminary hearing.
3. If not done previously, child(ren) will be decontaminated per the national protocol (see Procedure E details).
4. After an order from the court is obtained, DHS will transport children to out-of-home placement and explain the following to the children's caregivers:
  - a. The children were removed from a drug endangered home and had exposure to controlled substances and/or hazardous materials.
  - b. The children must be medically assessed pursuant to Procedure C.
  - c. The children will need additional exams/care within 30 days pursuant to OHS policy or a court order.
  - d. *If the children were taken from an operational meth lab, the following should also be explained to the caregiver:*
    - i. If child has not been properly decontaminated, the caregiver should immediately bathe the child with soap and warm water. Any contaminated clothing and coverings used for transport should either be cleaned by washing in hot water and laundry detergent separately from other clothing or placed in the garbage in a closed plastic bag.
    - ii. None of the child's personal belongings were removed from the home due to danger of chemical contamination.

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**I. LOCATION OF OTHER CHILDREN**

***Appropriate Responder: DHS***

1. OHS will attempt to locate all other children known to live in the drug home who were not present at the time of discovery.
2. DHS will arrange an initial child-friendly forensic interview to determine how many hours it has been since the children have been in the home and determine if an initial medical assessment is appropriate to determine whether children are in need of emergency care.

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**J. DOCUMENTATION OF CHILD ENDANGERMENT**

***Appropriate Responder: LEA and DHS***

*LEA should follow Michigan State Police Methamphetamine Protocol*

*OHS should follow Department of Human Services policy for documentation*

1. The clandestine/drug lab and/or anything else that can support a finding of child endangerment will be documented. The documentation should make clear the degree of accessibility to the child. Documentation will occur in writing, photos and/or video and will include any of the following risk factors:
  - a. Visible evidence of children's presence, particularly proximity of children's belongings to chemicals
  - b. Children's accessibility to drugs, drug residue, chemicals, syringes and drug paraphernalia
  - c. Proximity of hazards to children's play, sleep and eating areas
  - d. Other hazards and indications of neglect
  - e. Access to pornography
  - f. Access to weapons
  - g. Food quantity and quality
  - h. Sleeping conditions
  - i. Sanitary conditions
2. Document any surveillance equipment, weapons (note if loaded) and/or explosives (note if live).
3. Retrieve samples for forensic laboratory.
4. Interview neighbors and other witnesses as appropriate.
5. Dismantle meth lab (must be completed by personnel certified to dismantle clandestine labs)
6. LEA will share appropriate information and/or investigative reports regarding child endangerment with DHS.

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**K. COMPLETE MEDICAL EVALUATION OF CHILDREN**

***Appropriate Responder: Medical Doctor See Michigan DEC Medical Protocol***

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**L. PROSECUTION AND ADMINISTRATIVE FOLLOW-UP**

***Appropriate Responder: LEA, DHS, prosecution, medical providers***

1. LEA will complete necessary reports that include documentation of child endangerment and forward them to the local prosecuting attorney.
2. LEA will notify the local enforcing agency under Public Act 307 for all meth related incidents.
3. LEA, OHS and medical providers will coordinate exchange of information contained in OHS intake/investigation

report(s), medical report (including urine screen results), and LEA report. Each agency should ensure that the appropriate reports are forwarded to the prosecutor's office.

4. Pursuant to Public Act 256 of 2006, within 24 hours after DHS determines that a child was allowed to be exposed to or have contact with methamphetamine production, DHS shall submit a petition for authorization from the court under MCL 712A.2
5. The prosecuting attorney will review evidence and information gathered from other agencies and decide what legal action should be taken, including the following:
  - a. Filing criminal charges.
  - b. Filing child neglect petition in Family Court Division of Circuit Court.
  - c. Making referral of potential child abuse or neglect to Department of Human Services.
  - d. Notifying law enforcement of potential illegal drug activity (if law enforcement not yet involved).
  - e. Participating in forensic interview of drug endangered children.
6. Prosecutor should share all accessible information with other agencies and interested parties.
7. In the event that DHS does not substantiate abuse or neglect, the prosecutor should consider filing petition in family court without their involvement if situation so warrants.

**M. FOLLOW-UP CARE FOR CHILDREN**

***Appropriate Responder: DHS, medical/mental/developmental/dental health providers***

1. For children that are under the care and custody of the State of Michigan, DHS will ensure that all follow-up medical, dental, mental health and developmental evaluations are occurring as needed and all necessary treatment is being provided to the child.
2. DHS will collaborate with medical/mental/developmental health care providers to evaluate the needs of the children.
3. DHS will provide information on appropriate follow-up care to children's caregivers.
4. DHS should not allow child/parent visits to occur in homes that formerly housed meth labs unless it has been cleaned pursuant to PA 258 and 260 (check with local public health department to confirm). This is because presently, Michigan has no standardized method for tracking and certifying decontamination of such sites.

# Appendix

## G

STATE OF MICHIGAN  
GOVERNOR'S TASK FORCE ON CHILD ABUSE AND NEGLECT  
AND  
DEPARTMENT OF HUMAN SERVICES

**FORENSIC INTERVIEWING PROTOCOL**

Third Edition



This publication is also available on the Department of Human Services website at [www.michigan.gov/dhs](http://www.michigan.gov/dhs):

Select News, Publications & Information.  
Select Publications.

- Scroll or jump to the Children's Protective Services category and select Forensic Interviewing Protocol - DHS Pub 779.

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## PREFACE

In 1991, the Governor's Task Force on Children's Justice was created pursuant to federal legislation to respond to the tremendous challenges involved in the handling of cases of child abuse-particularly child sexual abuse-in Michigan. In August 1993, the Task Force published DHS Publication 794, *A Model Child Abuse Protocol- Coordinated Investigative Team Approach*.

In 1996, the DHS initiated the development of a forensic interviewing protocol by establishing a steering committee within DHS and enlisting nine county DHS offices to participate as pilot counties in testing the protocol. Debra Poole, Ph.D., of Central Michigan University was contracted by DHS to develop a forensic interviewing protocol. Independent of the DHS project, the Task Force also identified the objective of developing and implementing a forensic interviewing protocol. From 1996 to 1998, DHS and the Task Force worked together with Debra Poole in developing and implementing a protocol that would improve the interviewing techniques of all professionals involved in the investigation of child abuse, especially the sexual abuse of children, in Michigan. The first edition of the Forensic Interviewing Protocol was published in 1998.

In 1998, the Child Protection Law was amended to require each county to implement a standard child abuse and neglect investigation and interview protocol using as a model the protocols developed by the Task Force as published in DHS Publication 794, *A Model Child Abuse Protocol- Coordinated Investigative Team Approach* and DHS Publication 779, *Forensic Interviewing Protocol*, or an updated version of those publications.

In September of 2003, the Task Force convened a Forensic Interviewing Protocol Revision Committee to review the original Protocol. In April 2005, the second edition of the Protocol was published. The Committee was reconvened in late 2008. The review of the second edition of the Protocol was completed in 2011. After a careful and complete examination during both revisions, the Committee edited sections for clarity, improved the examples, added Quick Guides, and provided some additional reference material, including relevant statutes. Recent research continues to support the methodology used in Michigan's Protocol.

This Protocol should be used in conjunction with the Task Force DHS Publication 794, *A Model Child Abuse Protocol- Coordinated Investigative Team Approach*. Proper implementation of DHS Publication 779, *Forensic Interviewing Protocol* requires professional training. Professionals who have received appropriate training in the application of the Protocol should conduct the interviews of children. The Task Force was renamed the Governor's Task Force on Child Abuse and Neglect in 2010 to better reflect its mission.

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# forensic Interviewing Protocol

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## Introduction

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The goal of a forensic interview is to obtain a statement from a child, in a developmentally-sensitive, unbiased, and truth-seeking manner, that will support accurate and fair decision-making in the criminal justice and child welfare systems. Although information obtained from an investigative interview might be useful for making treatment decisions, the interview is not part of a treatment process. Forensic interviews should not be conducted by professionals who have an on-going or a planned therapeutic relationship with the child.

*forensic interviews are hypothesis-testing rather than hypothesis-confirming (see Quick Guide #1)*

There are two overriding features of a forensic interview:

- Hypothesis testing.  
A child-centered approach.

First, forensic interviews are hypothesis-testing rather than hypothesis-confirming (Ceci & Bruck, 1995). Interviewers prepare by generating a set of alternative hypotheses about the source and meaning of the allegations. During an interview, interviewers attempt to rule out alternative explanations for the allegations. For example, when children use terms that suggest sexual touching, interviewers assess the children's understanding of those terms and explore whether touching might have occurred in the context of routine caregiving or medical treatment. When children report details that seem inconsistent, interviewers try to clarify whether the events could have occurred as described, perhaps by exploring whether the children are describing more than one event or are using words in nonstandard ways. Before closing an interview, interviewers should be reasonably confident that the alleged actions are not subject to multiple interpretations and that any alleged perpetrators are clearly identified.

*forensic interviews should be child-centered (see Quick Guide #2)*

Second, forensic interviews are child-centered. Although interviewers direct the flow of conversation through a series of phases, children should determine the vocabulary and specific content of the conversation as much as possible. Forensic

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interviewers should avoid suggesting events that have not been mentioned by children or projecting adult interpretations onto situations (e.g., with comments such as "That must have been frightening").

## **Number of Interviewers**

Local customs and requirements often dictate how many professionals will be involved in conducting an interview. There are advantages and disadvantages to both single-interviewer and team (e.g., child protection and law enforcement) approaches. On the one hand, children may find it easier to build rapport and talk about sensitive issues with a single interviewer; on the other hand, team interviewing may ensure that a broader range of topics is covered and reduce the need for multiple interviews.

*one professional should be the primary interviewer, with the other taking a supportive role*

When two professionals will be present, it is best to appoint one as the primary interviewer, with the second professional taking notes or suggesting additional questions when the interview is drawing to a close. Before conducting the interview, interviewers should have sufficient preparation time to discuss the goals for the interview and the topics that need to be covered; interviewers should not discuss the case in front of the child. At the start of the interview, both interviewers should be clearly introduced to the child by name and job. Seating the second interviewer out of the line of sight of the child may make the interview seem less confrontational.

## **Support Persons**

The presence of social support persons during forensic interviews is discouraged. Although it makes intuitive sense that children might be more relaxed with social support, studies have failed to find consistent benefits from allowing support persons to be present during interviews (Davis & Bottoms, 2002). Support persons might be helpful during early portions of interviews, but they might also inhibit children from talking about sexual details. Individuals who might be accused of influencing children to discuss abuse, such as parents involved in custody disputes or therapists, should not be allowed to sit with children during interviews.

If the interviewer deems a support person necessary (a social worker or teacher, for example), this individual should be seated out of the child's line of sight to avoid criticism that the child was reacting to nonverbal signals from a trusted adult. In addition, the interviewer should instruct the support person that only the child is allowed to talk unless a question is directed to the support person.

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## **Videorecording or Audiorecording and Documentation**

The Governor's Task Force on Child Abuse and Neglect supports as a best practice the videorecording of investigative forensic interviews of children at child advocacy centers or in similar settings. If your county videorecords or audiorecords, follow the procedures suggested below.

A designated person should write on the recording label the interviewer's name, the child's name, the names of any observers, and the location, date, and time of the interview. Michigan law states, in part, that the *videorecorded statement shall state the date and time that the statement was taken; shall identify the persons present in the room and state whether they were present for the entire videorecording or only a portion of the videorecording; and shall show a time clock that is running during the taking of the statement* (see Appendix, *Videorecording Laws*). All persons present in the interview room should be clearly visible to the camera and positioned so as to be heard. Rooms should be large enough to place videorecording equipment at an acceptable distance from the child, but not so large that a single camera (or a two-camera setup) cannot monitor the entire room. Recording reduces the need to take notes during the interview. However, the interviewer may bring a list of topics to be discussed during the interview and may jot down notes during the interview to help remember which points need to be clarified.

If the interview is not being videorecorded or audiorecorded, it is paramount that the interviewer or a designated person accurately document what the child says. Beginning with introducing the topic, the interviewer should try to write down the exact wording of each question as well as the child's exact words. It is efficient to use abbreviations for common open-ended prompts (e.g., "TWH" for "then what happened" or "TMM" for "tell me more").

## **The Physical Setting**

The best environment for conducting forensic interviews is a center specifically equipped for this purpose. Centers often have comfortable waiting rooms with neutral toys and games, as well as interviewing rooms with video and audio links to observation rooms. The interview room should provide a relaxing environment that is not unnecessarily distracting to young children.

Interviewers who do not have access to an interviewing facility should try to arrange a physical setting that recreates some of the important features of specialized centers. First, select the most neutral location possible. For example, if the interview must be conducted in the home (in an emergency or if the child is preschool age or on school break), select a private location away from parents or siblings that appears to be the most neutral spot. Similarly, a

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*the interview room should be friendly but uncluttered and free from distracting noises and supplies*

speech-and-language room in a school might be a better choice than the principal's office because children often believe they are in trouble when they are called to the main office. Also, children may worry about being interviewed in a police station, and thus they might benefit from an explanation about why they are being interviewed there (e.g., "We like to talk to children over here because the rooms are nice and bright, and we won't be disturbed").

Second, select locations that are away from traffic, noise, or other disruptions. Items such as telephones, cell phones, televisions, and other potential distractions should be temporarily turned off.

Third, the interview room should be as simple and uncluttered as possible, containing a table and chairs. Avoid playrooms or other locations with visible toys and books that will distract children. Young children are usually more cooperative in a smaller space that does not contain extra furniture. Moreover, children pay more attention when attractive items such as computers are temporarily removed from the interview space.

## **Interviewer Guidelines**

Several guidelines about interviewer behavior, demeanor, and communication should be followed throughout the interview (adapted from Poole & Lamb, 1998):

*be relaxed and avoid emotional reactions to a child's description of abuse*

Avoid wearing uniforms or having guns visible during the interview.

Convey and maintain a relaxed, friendly atmosphere. Do not express surprise, disgust, disbelief, or other emotional reactions to descriptions of the abuse.

Avoid touching the child.

Do not use bathroom breaks or drinks as reinforcements for cooperating during the interview. Never make comments like "Let's finish up these questions and then I'll get you a drink."

Respect the child's personal space.

Do not stare at the child or sit uncomfortably close.

Do not suggest feelings or responses to the child. For example, do not say, "I know how *hard* this must be for you."

Do not make promises. For example, do not say, "Everything will be okay" or "You will never have to talk about this again."

Acknowledge and address the child's feelings if the child becomes upset, embarrassed, or scared, but avoid extensive comments about feelings. Comments such as "I talk with children about these sorts of things all the time; it's okay to talk with me about this" can be helpful.

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Do not make comments such as "Good girl" or "We're buddies, aren't we?" that might be interpreted as reinforcing the child for talking about abuse issues. Supportive comments should be clearly noncontingent; in other words, encouragements should not be based on the child talking about specific types of issues. The best time to encourage children is during initial rapport building and at the close of the interview, after the conversation has shifted to neutral topics.

Do not use the words "pretend" or "imagine" or other words that suggest fantasy or play.

Avoid asking questions about why the child behaved in a particular way (e.g., "Why didn't you tell your mother that night?"). Young children have difficulty answering such questions and may believe that you are blaming them for the situation.

Avoid correcting the child's behavior unnecessarily during the interview. It can be helpful to direct the child's attention with meaningful explanations (e.g., "I have a little trouble hearing, so it helps me a lot if you look at me when you are talking so that I can hear you") but avoid correcting nervous or avoidant behavior that is not preventing the interview from proceeding.

- Ask the child to repeat the comment if you have difficulty understanding what the child said. Use phrases such as "What did you say?" or "I couldn't hear that, can you say that again?" instead of guessing (e.g., "Did you say [word or phrase supplied by interviewer]?"). Young children will often go along with an adult's interpretation of their words. Be tolerant of pauses in the conversation. It is appropriate to look away and give the child time to continue talking. Similarly, it is often helpful to take a few moments to formulate your next question.

Avoid giving gifts to the child.

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## The Phased Interview

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Most current protocols advise interviewers to proceed through a series of distinct interviewing stages, with each stage accomplishing a specific purpose.<sup>1</sup> The goals of empowering children to be informative and minimizing suggestive influences are accomplished by three major guidelines:

- Interviewers give children clear information about the interviewer's job and the ground rules for the interview.
- Interviewers build rapport in a way that invites children to talk.
- Interviewers encourage children to describe information using their own words.

Some investigations require more than one interview with a child. Interviewers should cover all of the phases even when children have participated in a previous forensic interview.

This Protocol describes the general structure of a phased interview but does not dictate which specific questions interviewers will ask. Although the series of phases is specified, the structure gives the interviewer flexibility to cover any topics the investigative team determines are relevant, in any order that seems appropriate.

The interview includes eight phases:

- Prepare for the Interview.
- Introduce Yourself and Build Rapport.
- Establish the Ground Rules.
- Conduct a Practice Interview.
- Introduce the Topic.
- Elicit a Free Narrative.
- Question and Clarify.
- Close the Interview.

When necessary, these phases can be varied to accommodate children's initial comments, their ages, and their levels of cognitive development. For example, some children begin to discuss allegations without prompting. In such cases, the interviewer should not interrupt until it is clear that the child has finished giving a free narrative. Moreover, placement of the ground rules is flexible, and interviewers can remind children about the ground

*a summary of the interview phases appears in Quick Guide #3*

1. See End Notes

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rules at any point during the interview. Some interviewers prefer to establish the ground rules before building rapport. This gives them a chance to review the rules during informal conversation. However, small children may not keep ground rules in mind throughout the interview, so some interviewers introduce the ground rules after building initial rapport.

The purpose of the phases is to encourage interviewers to introduce themselves to children, build rapport, deliver age-appropriate instructions, allow children to talk about their lives in their own words, and use follow-up questions to clarify ambiguities in the reports. Within this framework, interviewers can select approaches that match their styles of interviewing, the ages and needs of individual children, and the specifics of individual cases.

## **Prepare for the Interview**

There are several things an interviewer should do when preparing for an interview:

- Gather background information.  
Generate alternative hypotheses and hypothesis-testing questions.  
Set up the interview environment.

Pre-interview preparation will vary depending upon the nature of the allegations, the available resources, and the amount of time before an interview is conducted. If physical evidence is available, the interviewer should consult with the investigative team to consider several questions before deciding whether or not to use the physical evidence during the forensic interview (See Quick Guide #6: Guidelines for Use of Physical Evidence).

### **Gather Background Information**

It is more important to collect background material when the child is preschool age, when the allegations are based on ambiguous information (such as sexual acting out), or when factors such as medical treatment or family hostilities might complicate the investigation. Relevant information can be obtained from a variety of sources, including children's protective services files, police reports, and collateral interviews with the reporting person and/or family members.'

The following list of topics illustrates the types of information that might be useful for interviews about child sexual abuse allegations (from Poole & Lamb, 1998, adapted with permission from the American Psychological Association):

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*interviewers tailor their interview preparations to the needs of each case, collecting information that will help build rapport with the child and help test alternative hypotheses about the meaning of the child's comments*

The child's name, age, sex, and relevant developmental or cultural considerations (e.g., developmental delay, hearing or speech impairment, bilingualism).

The child's interests or hobbies that could be used to develop rapport.

Family composition/custody arrangements.

Family members' and relevant friends' or caregivers' names (especially how the child refers to significant others, with special attention to nicknames and duplicate names).

- Caregiving environments and schedules, with the child's names for these environments.
- Relevant medical treatment or conditions (e.g., genital rashes, assistance with toileting, suppositories, or recent experiences with rectal thermometers).

Family habits or events related to allegation issues (e.g., showering or bathing with the child, a mother who allows children in the bathroom while she changes tampons, physical play, or tickling.)

The content of recent sex education or abuse prevention programs.

The family's names for body parts.

The nature of the allegation and circumstances surrounding the allegation.

Possible misunderstanding of the event.

Possible motivations for false allegations (e.g., family or neighborhood hostilities that predate suspicions of inappropriate behavior).

### **Generate Alternative Hypotheses and Hypothesis-Testing Questions**

*interviewers consider alternative hypotheses and plan questions to test them*

Forensic interviews are hypothesis-testing rather than hypothesis-confirming. Interviewers prepare by generating a set of alternative hypotheses about the source and meaning of the allegations. Interviewers should plan the following:

Questions to test alternative hypotheses about how the allegations arose.

- Questions to test alternative interpretations of details stated in the allegation.

*see Quick Guide # 1: Alternative Hypotheses Questions and Planning Form*

For example, if there is an allegation that a babysitter touched a child in a sexual way, an alternative hypothesis is that the touching occurred during routine caregiving (such as wiping after a bowel movement). In this case, after the child states that he or she was touched on the butt by the babysitter, the question "What were you

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doing when the babysitter touched you on the butt?" could be the first of a series of questions during the question and clarify phase to determine if the babysitter was cleaning the child. Similarly, if the child allegedly told her mother about a "butt licking game," the question "Who plays the butt licking game?" could test the hypothesis that the game is a joke about the family's new puppy.

### **Set Up the Interview Environment**

The interviewer should remove distracting material from the room and position the chairs and recording equipment before introducing the child to the interview room. It is a good idea to be sure that the child has had a recent bathroom break and is not hungry before beginning the interview. Avoid scheduling an interview at the child's nap time (See The Physical Setting on page 3).

### **Introduce Yourself and Build Rapport**

The purpose of the introduction is to acclimate the child to the interview, modeling a relaxed and patient tone that will be carried throughout the interview. Sometimes children were not informed or were misinformed by a parent or caregiver about the circumstances of the interview. When this happens, children are often confused about the purpose of the interview or worried that they are in trouble. Moreover, children take time to adjust to new environments and may be temporarily distracted by the sights and sounds of the interviewing room.

*children pay more attention when they are familiar with the environment and have some understanding about what will happen*

After the child and the interviewer are seated, the interviewer begins by giving a brief explanation of the interviewer's job. Introductions can be brief or long, depending upon how relaxed the child appears. The following is a simple example:

"Hello, my name is [interviewer's name]. My job is to listen to kids. Today is my day to listen to you."

Children might be confused about being questioned by a police officer or other professional, so interviewers are free to explain more about their job (e.g., "Do you know what a social worker/police officer does? Well, part of my job is to talk with children and to help them. I talk with a lot of children in [name of town]"). If children seem apprehensive, it is appropriate to provide some orienting information about the interview (e.g., "I talk with a lot of children about things that have happened. We are going to talk for a while and then I'll take you back to the other room where your mom [dad, etc.] is waiting for you"). The interviewer may want to talk informally to get to know the child.

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If the interview is being recorded, the interviewer tells the child about the equipment and the purpose of the recording. The child should be given an opportunity to glance around the room, and school-age children could be allowed to inspect the recording equipment if they choose. The following is an example:

"As you can see, I have a video camera/recorder here. It will record what we say. Sometimes I forget things and the recording helps me remember what you said."

There are varying views about whether or not to introduce the child to observers or let the child view the observation room before the interview. Generally, children have no concerns or objections with being recorded or observed.

*building rapport begins with the initial introduction and continues throughout the interview*

Building rapport begins with the initial introduction and continues throughout the interview. Appearing relaxed, friendly, and interested allows the interviewer to engage with the child. In daily conversations, adults tend to dominate conversations with children by asking numerous specific questions. Many children therefore expect that interviewers will ask a lot of questions and that their job is to respond to each one with a short answer. The purposes of rapport building are to:

- Make the child comfortable with the interview setting.
- Gather preliminary information about the child's verbal skills and cognitive maturity.
- Convey that the goal of the interview is for the *child* to talk.

*ask open-ended questions that invite the child to talk*

Transcripts of investigative interviews show that many interviewers build rapport by asking questions about the child's teacher, family, and likes or dislikes. Although such questions are useful for starting the interview, questions that can be answered in one or two words may lead the child to expect that the interviewer will control the conversation. During early conversations, questions that invite the child to talk (e.g., "Tell me about your family") are better than more focused questions (e.g., "How many brothers and sisters do you have?") .

During the rapport phase, interviewers can encourage a reluctant child with comments such as "It is okay to start talking now" or "This is your special time to talk. I want you to be the talker today and I'll listen."

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## Establish the Ground Rules

There are four main ground rules to establish:

- Don't guess at answers.
- Tell me if you don't understand something I say.
- Correct me if I make a mistake.
- Tell the truth.

Studies have shown that children sometimes try to answer questions even when they have no basis for answering or the questions do not make sense. Also, children often fail to correct interviewers who misunderstand what they say. During the ground rules phase, the interviewer motivates the child to answer accurately with a series of simple instructions, as in the following examples:

*allow the child to demonstrate understanding of the rules with practice questions and verbal responses*

Don't guess. "Now that I know you better, I want to talk about some rules we have in this room. One rule is that we don't guess. If I ask a question and you don't know the answer, just say, 'I don't know.' For example, what is my dog's name?" Wait for answer. "That's correct, you don't know my dog's name, so 'I don't know' is the right thing to say. Will you promise not to guess at answers?"

*the word gridelin means a color mixed of white and red, or a gray violet color*

Tell me if you don't understand. "Another rule is that if I say something you don't understand, you should tell me you don't understand. For example, is my shirt gridelin? Wait for child to say "I don't know what that means." "Thank you for telling me you didn't understand. I'll ask you a different way. What color is my shirt? Will you tell me when you don't understand something?"

Correct me if I make a mistake. "Sometimes people say something wrong by mistake. If I say something wrong, I want you to tell me. For example, how do you like being 7 years old (to a 6-year-old)?" Wait for answer. "That's right; you're not 7 years old, so I'm glad you told me. Will you correct me if I say something wrong?"

As part of the ground rules phase, interviewers should discuss truth/lies and obtain verbal agreement from children that they intend to tell the truth. The purpose of discussing truth/lies is to motivate children to provide accurate descriptions and report only events that really happened. A discussion of truth/lies can be delayed until the interviewer has built rapport with the child, or omitted if a supervisor advises against these questions.

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*use concrete statements, such as, "I am sitting. Is that true or not true (a lie)?" rather than abstract questions, such as "What does it mean to tell the truth?"*

The interviewer starts the discussion of truth/lies by demonstrating that the child understands the difference between the truth and a lie, and the importance of telling the truth. This is accomplished by asking the child to label statements as "true" ("right") or "not true" ("a lie" or "wrong"), after which the interviewer asks for verbal acknowledgement that the child will tell the truth. Interviewers should avoid asking the child to define these concepts with questions such as "What does it mean to tell a lie?" or "Can you tell me what the truth is?". These questions are difficult for children to answer and often lead to confusion. Questions like the ones that follow complete the ground rules phase:

**Truth/lies.** I need to make sure you know what the truth is. I'm sitting down right now. Is that true or not true (a lie)?" Wait for answer. "That's right; I *am* sitting down, so sitting down is the truth. You are running right now. Is that true or not true (a lie)? That's right, you are sitting, so saying you are running is not true (a lie). I see you understand what the truth is. This room is a place where you should always tell the truth. While we are talking today, it is important to tell me the truth-what really happened. Will you tell me the truth today?" Wait for answer.

## **Conduct a Practice Interview**

*ask the child to describe a recent event from beginning to end*

There are four general principles for an interviewer conducting a practice interview:

Elicit information using only open-ended prompts that invite the child to provide multiple-word responses, such as, "Tell me everything about [child's neutral event]."

Invite the child to be informative with comments such as "Tell me everything that happened, even little things you don't think are very important" or "Tell me everything that happened, from the very beginning to the very end."

Encourage the child to talk during this phase of the interview with head nods, exclamations (e.g., "Ohhhh"), partial repetitions of the child's last comment (e.g., Child: "And then he opened my present by mistake." Interviewer: "Oh, he opened your present"), or even more direct encouragement (e.g., "You told me a lot about your birthday; I know a lot more about you now").

- Reinforce the ground rules.

*use open-ended prompts such as "and then what happened?"*

A practice interview helps children understand and learn that *they* are the information providers. Also, asking children to describe a neutral event gives the interviewer opportunities to revisit important ground rules. One way to conduct a practice interview

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is to identify (during interview preparation) a specific event that the child recently experienced (or experienced around the time of the alleged abuse). Events used to train the child to talk could be a birthday party, a recent holiday celebration, an event at school, or a significant family event (e.g., getting a new puppy). The interviewer asks the child to describe this event in detail, using open-ended prompts, and conveys interest with everything the child has to say, as in the following example (Orbach *et al.*, 2000):

*encourage the child to talk by showing interest and by not interrupting*

"A few days ago (or a few weeks ago) was your birthday (Thanksgiving, Christmas, etc.). Tell me about your birthday (Thanksgiving, Christmas, etc.)."

"I want you to tell me all about your birthday (Thanksgiving, Christmas, etc.). Think again about your birthday and tell me what happened from the time you got up that morning until the time you went to bed that night (or some incident or event the child mentioned)."

- "Then what happened?"
- "Tell me everything that happened after [incident mentioned by the child]."  
"Tell me more about [something the child just mentioned]."
- "It's really important that you tell me everything about things that have happened to you."

*children who have little to say about specific events may be able to describe a repeated, scripted event*

Young children often have little to say about one-time events. If this is the case, it can be helpful to ask the child to describe a recurring, scripted event. A script is a general description of repeated events, such as what the child does to get ready for school each morning, what happens during a trip to the child's favorite fast-food restaurant, or how the child plays a favorite game. The following are examples designed to elicit scripted events:

- "I'd like to get to know a little bit more about you and your family. Tell me what you do every morning when you wake up." If further prompts are necessary, a child may be asked "Tell me everything from the time you wake up until the time you get to school. Then what do you do? And then what do you do next?" After the child stops talking, "Okay. And then what happens?"
- "I talk with a lot of children, and most of them really like to get hamburgers or pizza at their favorite restaurant. Do you have a favorite place to eat? Good. Tell me about everything that happens when you take a trip to [restaurant] to eat [food]. Tell me how you get there. Then what happens?"

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To engage a reluctant child, it may be helpful to express interest in a topic the child is an "expert" on and ask them to tell you about the topic:

"I talked with your mom yesterday and she said you really like to play [soccer, baseball, video games]. I don't know much about playing [game child likes] but I've heard a lot about it. Tell me all about [game child likes] so I'll know all about it too."

## **Introduce the Topic**

The substantive portion of the interview begins when the interviewer prompts a transition to the target topic. Here are some transition examples:

- "Now that I know you a little better, it's time to talk about something else."  
"Now that we know each other a little better, I want to talk about the reason that you are here today."
- "Now it's time to talk about something else."

Interviewers should start with the least suggestive prompt that might raise the topic, avoiding mention of particular individuals or abuse:

- "Tell me the reason you are here today."
- "Do you know the reason I came to talk with you?"

*start with the least suggestive prompts that might raise the topic of abuse (See Quick Guide #7)*

If the child does not respond to these neutral prompts, the interviewer progresses to more specific opening remarks, still avoiding mention of a particular behavior. Also, it is best to avoid words such as hurt, bad, abuse, or other terms that project adult interpretations of the allegation. For example, an interviewer should not introduce the topic of sexual abuse using the terms "good touch or bad touch." Examples include the following:

- "I understand something has been bothering you."  
"Does your mom think that something has been bothering you?"
- "I understand there are some problems in your family (at camp, etc.). Tell me about them."  
"I know that you had to move recently, and Mr./Mrs. [name of caregiver] is taking care of you now. Tell me how that happened."  
"I heard you visited the doctor yesterday. Tell me about visiting the doctor."
- "I see you have a cast on your arm. What happened?"

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"I understand that the police came to your house last night. Tell me what happened."

"I understand you were playing with someone yesterday and your teacher wanted you to stop playing. Tell me about that."

Some interviewers use the techniques listed below when children fail to respond to the above invitations:

- Ask what the child's favorite thing and least favorite thing is about various people in the child's life (Morgan, 1995).
- Ask "Who are the people you like to be with?" and "Who are the people you don't like to be with?" (Yuille, *et al.*, 1993).  
Explore the topic indirectly by asking "Is there something you are worried about if you talk with me today?"  
Give the child more control over the interview by changing the seating, removing a second interviewer, or letting the child write an initial answer on paper.
- Ask "Is there something that would make it easier for you to talk with me today?"

The goal of these techniques is to avoid asking the child a direct question, such as "Did somebody touch your privates last week?" Research shows some children (particularly preschoolers and children who have heard events discussed by adults) will say "yes" to these direct questions even when the events have not occurred (Myers *et al.*, 2003; Poole & Lindsay, 2002). Consequently, answers to direct questions are less informative than answers to open-ended questions. Furthermore, direct questions about touching may elicit responses about routine caregiving (e.g., bathing, temperature-taking) or other sources of knowledge (e.g., information from a recent sexual abuse prevention program) that could escalate into false allegations, especially when these questions are followed by numerous specific questions. If the interviewer asks a direct question, it is important to shift to open-ended questions that encourage the child to describe events in his or her own words.

*see Quick Guide #4: Hierarchy of Interview Questions*

*closing the interview without a report of abuse is an acceptable outcome*

Closing the interview without a report of abuse is an acceptable outcome. There are many reasons why a child may not disclose: because the abuse didn't occur, because the child is frightened or does not want to get a loved one in trouble, or because the event was not especially memorable and the child is not recalling the target event at this particular moment.

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## Elicit a Free Narrative

After the topic is raised, the interviewer asks the child to provide a narrative description of the event. Research shows that children's responses to open-ended prompts are longer and more detailed than responses to focused questions (e.g., Lamb *et al.*, 2008; Orbach & Lamb, 2000). Answers to open-ended questions are more accurate than answers to focused questions because many children answer focused questions even when they do not remember relevant information (e.g., Poole & Lindsay, 2001). **The most common interviewer errors are omitting the free narrative phase or shifting prematurely to specific questions.** Instead of asking the child to talk about the event and then shifting to specific questions and clarification, the interviewer should prolong the free narrative phase with numerous open-ended prompts, such as "And then what happened?" and "Tell me more about [child's words for the event]."

To elicit a free narrative, the interviewer simply tacks on an open invitation after the topic is raised:

- "Tell me everything you can about [refer back to child's statement]."
- "I want to understand everything about [refer back to child's statement]. Start with the first thing that happened and tell me everything you can, even things you don't think are very important."
- "Tell me all about [refer back to child's statement] from the very beginning to the very end."

After the child begins talking, the interviewer should be patient about pauses in the conversation and not feel pressured to jump to another prompt or question right away. Instead, the interviewer should wait for the child to continue talking. Silence is a powerful tool in the interviewing process. The interviewer's continued silence can exert a subtle but gentle pressure on the child to respond. Only when the interviewer is sure that the child is done responding should another prompt be given.

The interviewer can encourage the child's free narrative with open-ended comments such as "Then what?," "Tell me more," or "What else can you tell me about [refer back to child's statement]?" The interviewer can also motivate the child with neutral acknowledgments (e.g., "uh huh"), by repeating the child's comments (e.g., "He turned on the TV. Then what happened?"), or by giving the child permission to talk about the target issues (e.g., "It's okay to say it"). Interviewers can remind the child that they are used to talking about such things, perhaps with a comment such as "I talk with a lot of children about these sorts of things. It's okay to tell me all about it, from the very beginning to the very end."

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*encourage the child to describe the event in the child's own words by using open-ended invitations such as, "tell me everything about [refer back to child's statement]"*

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*be tolerant of pauses in the conversation*

If a child becomes non-responsive or upset, acknowledge the child's behavior and address it but avoid extensive comments. Give the child time to respond or to regain composure. If a child remains non-responsive, it may help to gently tell the child "You've stopped talking." If a child remains upset, it may help to restate the child's last statement. It may help to respond "I see you are crying. Tell me what's going on."

Children often make comments that adults do not understand or refer to people who have not yet been identified. Interrupting the child to request an immediate clarification may inhibit the child from talking. It is better to encourage the child by using general prompts such as "Then what?" before entering the question and clarify phase. Interviewers can jot down short notes while the child is talking to remind themselves to revisit specific information later in the interview.

## **Question and Clarify**

*(see Quick Guides #2, #4, and #5)*

The question and clarify phase begins after it is clear that the child has finished providing a free narrative. This phase is the time to clarify the child's comments and seek legally relevant information. The interviewer should consider how directly a child should be prompted using the hierarchy of questions and taking into consideration the amount of corroborating evidence and the safety of the child. The interviewer may want to consult with their investigative team (See Quick Guide #2: Guidelines for Questioning Children, Quick Guide #4: Hierarchy of Interview Questions, and Quick Guide #5: Question Frames).

Interviewers should avoid jumping from topic to topic. In general, it is best to build the questions around the child's free narrative. For example, if the child reported a single event, the interviewer would clarify information about that event before asking whether there have been other similar events.

During the question and clarify phase, the interviewer should clarify:

- Descriptions of events.
- The identity of the perpetrator(s).  
Whether allegations involve a single event or multiple events.
- The presence and identities of other witnesses.
- Whether similar events have happened to other children.  
Whether the child told anyone about the event(s).  
The time frame and location/venue.
- Alternative explanations for the allegations.

Other topics may be important, depending upon the specific case, such as descriptions of physical evidence retrieved from the

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crime scene (e.g., a description of cameras if pictures were taken). However, interviewers should avoid probing for unnecessary details. For example, it may not be essential to get a detailed description of an alleged perpetrator if the accused is someone who is familiar to the child (e.g., a relative or teacher). Although it is useful if the child can recall when and where each event occurred, children may have difficulty specifying this information if they are young, if the event happened a long time ago, or if there has been ongoing abuse over a period of time (See Special Topics on page 22 for a discussion of general guidelines for investigating the time element in child criminal sexual conduct cases).

Because children usually volunteer only a portion of what they remember in response to each question or prompt, it may take a series of prompts to elicit complete descriptions of individual events and details. For example, if a child mentions that a man showed her "a bad cartoon," the interviewer should begin with an open-ended question such as "You said something about a bad cartoon. Tell me about the cartoon." In order to gain further details, the interviewer may have to ask questions such as "What did the cartoon look like?", "Did he show you one cartoon or more than one cartoon?", "Tell me what the second cartoon looked like", and "Was the cartoon on paper, on a computer, or something else?"

*use the least suggestive question possible, attempting to obtain a complete description of one event before shifting to a different topic (see Quick Guide #4)*

Interviewers should always use the most open-ended questions possible while questioning and clarifying. If a specific question is necessary to raise an issue, interviewers should follow it up with an open-ended question. For example, if objects were retrieved from the scene of the alleged event, the question "Did he bring anything with him when he came to see you?" might be followed by "Tell me what those things looked like." Following the terminology used in the *Memorandum of Good Practice* (Home Office, 1992), questions can be ordered along a continuum from least suggestive (open-ended questions) to most suggestive (leading questions). The following hierarchy describes this progression of question types. Interviewers should try to use questions at the top of the hierarchy and avoid leading questions altogether (See Quick Guide #4: Hierarchy of Interview Questions).

*when prompting the child to tell you "everything," be aware that delayed disclosure and disclosure in stages can occur*

**Open-ended questions/prompts** allow children to select which details they will report and generally require multiple-word responses. Open-ended prompts ask children to expand, (e.g., "You said Dad hit you with a belt. Tell me everything about Dad hitting you with a belt"), provide physical descriptions (e.g., "What did the belt look like?"), and clarify apparent contradictions (e.g., "You said you were alone, but then you said your mom heard you talking. I'm confused about that. Help me understand").

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*obtaining complete information  
in one interview may not always  
be possible*

Open-ended prompts can also elicit information about physical surroundings and conversation. For example, even preschoolers can respond accurately to the following prompts (Poole & Lindsay, 2001, 2002):

"Sometimes we remember a lot about how things looked. Think about all the things that were in the room where [child report of event]. Tell me how everything looked."

- "Sometimes we remember a lot about sounds and things that people said. Tell me all the things you heard when [child report of event]."

**Specific but nonleading questions** ask for details about information the child has already mentioned and can be answered with a word or brief comment. Specific but nonleading questions might ask about the context of an event (e.g., "Tell me what you were doing when [event child described]"), request clarification (e.g., "You said 'Bob.' Who is Bob?"), or ask about a specific detail (e.g., "What color was the towel?").

**Closed questions** provide only a limited number of response options. Multiple-choice questions and yes-no questions are closed questions. These questions are more risky than open-ended or specific questions because children sometimes feel they should choose one of the options. Therefore, responses to these questions are generally less accurate than responses to more open-ended questions. If the interviewer wants to confirm a specific detail of an allegation and the child seems confused by open-ended or specific questions, it is best to delete the correct answer from a multiple-choice question. If an event allegedly happened in the bathroom, for example, the interviewer might ask, "Where did that happen, in the bedroom, the kitchen, or in another place?" Closed questions should be followed by open-ended questions to show that the child can provide information spontaneously. Because yes-no questions are considered inherently leading by some experts, such questions should be used with caution, particularly with preschoolers. When yes-no questions are deemed necessary, it is useful to remind children that they should not guess. Interviewers should follow up with an open-ended question or prompt.

**Leading questions** imply an answer or assume facts that might be in dispute. Determination of whether a question is leading depends upon a host of variables, including the child's age, the child's maturity, and the tone of voice of the interviewer (Fallon & Pucci, 1994). Tag questions, such as "And then he touched you, didn't he?", are explicitly leading, as is any question that includes information the child has not yet volunteered.

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During this phase, the interviewer should continually monitor that the child's statements are unambiguous. If the child talks about "Grandpa," the interviewer should determine which individual is being discussed (e.g., "Which grandpa?", "Does Grandpa have another name?", "Do you have one grandpa or more than one grandpa?"). Similarly, if the child uses an unusual word (e.g., "my hot dog," "my tushee"), the interviewer should attempt to clearly identify what that word means to the child (e.g., "Tell me what your hot dog is").

*young children may stray off topic and begin to discuss other events during this phase of the interview*

If young children stray off topic and begin to discuss other events during this phase of the interview, it is important that the interviewer reiterate the topic under discussion. For example, it is very helpful to begin questions with identifying comments such as "About this time in the kitchen with Uncle Bill, [refer back to child's statement]." If the child reports new or unusual information, it is best to ask something like "Are you talking about that time Uncle Bill grabbed your privates, or is this another time?" It is easier for children to stay on topic if the interviewer warns the child when the topic is shifting (e.g., "I'm confused about that time in the park. Let me ask you something about that"). Another strategy to avoid confusion is to verbally label events that the interviewer might want to return to later in the interview (e.g., "Okay, let's call that the kitchen time") (Yuille *et al.*, 1993).

*ask questions in an order corresponding to the sequence of the child's free narrative*

Interviewers should avoid covering topics in a predetermined order. Instead, they should follow the child's train of thought and ask questions that are related to the child's narrative. In sexual abuse cases, the interviewer may need to ask whether the alleged event happened one time or more than one time, whether the child has knowledge that other children had a similar experience, and whether other individuals were present. Before ending this phase, the interviewer should ensure they elicited all the information possible from the child. For example, if a child made a disclosure, asking "Is there something else you'd like to tell me about [event the child described]?" or "Did I forget to ask you anything?" can be helpful. Lastly, all references to people and events should be clarified to ensure there is only one interpretation of the child's statements.

During the question and clarify phase, the interviewer listens to the child, mentally reviews the information already provided, makes decisions about further questioning, explores alternative hypotheses, and decides when to close the interview. Interviewers should maintain a relaxed manner and feel free to take a few minutes to collect their thoughts before deciding how to proceed. If there is a second interviewer or team members in an adjoining observation

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## **Close the Interview**

room, the interviewer can ask these individuals whether or not they have any additional questions before closing the interview.

The phase closing the interview includes three major objectives:

- Answering questions from the child.
- Reverting to a neutral topic.
- Thanking the child.

Regardless of the outcome of the interview, interviewers should ask children if they have any questions. It is important to answer questions truthfully and to avoid making promises (for example, saying that the child will not have to talk about the abuse again). It is appropriate to chat about neutral topics for a few minutes in order to end the interview on a relaxed note. The interviewer can return to topics discussed while building rapport and in the practice interview. The interviewer should thank the child for coming but should be careful not to specifically thank the child for disclosing abuse.

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## Special Topics

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### Questions about Time

There are several reasons why it can be very difficult for children to describe *when* an event happened. In their language development, children learn words that mark temporal relationships only gradually. Three-year-olds, for example, often use "yesterday" to mean "not today," and the words "before" and "after" are poorly understood before 7 years of age or even older (Walker, 1999). Regarding temporal concepts, children's understanding of dates and clock time is limited before 8-10 years of age. Often, children simply fail to remember exactly when target events occurred. Memory failure is common when events occurred a long time ago and when there were many similar events.

Interviewers should try to identify when events occurred, but young children sometimes answer inaccurately when questions demand details they cannot provide. For example, children sometimes try to answer questions about the day of the week or the time of day even when they are uncertain. Therefore, interviewers should try to determine when events occurred by asking about the context of the events. General questions about what grade the child was in, how old the child was, or whether it was summer vacation can narrow down the time. Similarly, knowing that the child was playing with a toy received for Christmas will date the event after Christmas, and questions about what TV show the child was watching will identify a time of day. Some interviewers ask children to point to a "time line" that contains pictures of holidays and other events, but there is no evidence that preschool children report the timing of past events more accurately with this aid than with developmentally-appropriate verbal questions (Malloy & Poole, 2002).

Interviewers should be aware that time is not an element in child criminal sexual conduct cases in Michigan. The Michigan Court of Appeals set forth four factors to consider when determining how specific the time of assault must be: the nature of the crime charged, the victim's ability to specify a date, the prosecutor's efforts to pinpoint a date, and the prejudice to the defendant in preparing a defense (*People v. Naugle*, 152 Mich. App 227, 233; 393 NW2d 592 1986).

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## Interviewing Aids

Interviewers should not use anatomical dolls or body diagrams to elicit disclosures. Most interviews can be successfully conducted without these interviewing aids. Guidelines on anatomical dolls state that children's behavior with dolls is not diagnostic of abuse. Consequently, interviewers can be accused of suggesting sexual themes if they introduce aids before children have mentioned abuse (Dickinson, *et al.*, 2005). Asking children to label body parts and then asking if they have been touched in any of the mentioned places is suggestive, and research has not shown that children's testimonial accuracy is improved when interviewers use body diagrams to elicit disclosures (Poole *et al.*, in press). It is less controversial to introduce interviewing aids during the question and clarify phase of the interview, when aids help to clear up ambiguities in children's reports (Everson & Boat, 2002). If the interviewer deems their use necessary, interviewing aids can be used during the Question and Clarify phase.

Anatomical body diagrams depicting various ages are available on the Prosecuting Attorneys Association of Michigan (PAAM) website at [www.michiganprosecutor.org/cats](http://www.michiganprosecutor.org/cats):

Select Resources.

Select the drawing you would like to access and print.

## Communication Issues

Interviewers should identify, during their interview preparation, whether children have special communication issues that require accommodation. Separate developmental assessments are not routinely required or useful, but they may be helpful for children who suffer from a developmental disability or have language limitations that raise questions about their ability to respond accurately to questions.

### Preschoolers

Whenever possible, interviews with preschool children should be scheduled for a time of the day when the children are usually alert and have recently had a snack. No special adjustments to the Protocol are required for preschool children, but interviewers should be aware that young children are more likely than older children to answer closed questions when they do not really know the answer. When interviewers use closed questions with young children, it is helpful to demonstrate that they are not simply guessing. For example, omitting the correct answer from multiple choice questions will reduce concerns about acquiescence.

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## **Bilingual Children**

During pre-interview preparation, interviewers should make their best determination of the child's primary language based on information from available sources, such as official records, consultations with parents or school officials, and the child's self-report. Arrangements should be made for an interpreter of the child's primary mode of communication whenever there is concern that a child faces limitations in understanding or speaking English. An interpreter, if needed, should not be an individual who might have an interest in the outcome of the case. An interpreter should translate exactly (or as closely as possible) what the interviewer and child say during the interview.

## **Augmentative and Alternative Communication (AAC)**

Augmentative and Alternative Communication (AAC) refers to communication systems that help children express themselves when they cannot communicate by producing typical speech or writing. AAC allows children to communicate *independently* through the use of eye gaze, picture boards, computer-based technologies, or other systems. The professional who has had the most contact with the child (and/or the development of the child's communication system) and an independent specialist should be involved in evaluating the needs of a child who communicates via AAC.

*facilitated communication is not a scientifically supported alternative to speaking or augmentative and alternative communication*

Unlike AAC, facilitated communication involves techniques in which adults touch or support children's arms or hands while the children interact with a keyboard or other device. Research clearly demonstrates that information obtained through facilitated communication often reflects the adults' knowledge. Thus, facilitated communication is not a scientifically supported alternative to speaking or AAC (American Academy of Child and Adolescent Psychiatry, 1994; American Psychological Association, 1994).

## **Developmental Disabilities**

Chronic health problems and perceptual, movement, language, cognitive, and emotional disorders can influence a child's ability to participate in a forensic interview. The simplest approach for most children is the developmentally-sensitive, child-centered interview, one in which the interviewer plans procedures that help individuals of all ages understand and respond to questions.

If an initial interview is unsuccessful, and interviewers have the resources, it may be helpful to conduct a second interview, taking a more comprehensive approach to planning for individual needs. For example, it may be helpful to determine the child's primary and secondary diagnoses and educational accommodations (if any) to anticipate the child's strengths and areas of difficulty.

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## Quick Guide #1: Alternative Hypotheses Questions and Planning Form

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During pre-interview preparation, interviewers generate a set of alternative hypotheses about the source and meaning of the allegations. During the Question and Clarify phase, interviewers attempt to rule out alternative explanations for the allegations.

There are numerous alternative hypotheses to allegations of abuse and neglect. These include honest mistakes and misunderstandings, unintentional influence of the child, intentional influence of the child, and a child's decision to lie for attention or to achieve another goal. The following are some examples:

- Someone misunderstood the child's statement.  
The child was abused but misidentified the perpetrator.  
An injury was accidental.
- A rash was caused by a medical condition.
- An injury resulted from a medical condition (e.g., falling down from a seizure).
- Touching occurred during routine caregiving.  
The child witnessed, but did not experience, the alleged abuse.
- Repeated questioning made the child believe abuse occurred.
- Someone coached the child to report abuse.  
The child wanted to retaliate against the accused.  
The child made up a story to get out of trouble.
- The child reported sexual abuse to cover for evidence of sexual activity.
- The child lied about abuse or neglect to attempt to change a living or visitation arrangement.
- The child exaggerated about an event to show off to friends.  
The child lied about who the perpetrator was to protect the actual perpetrator.

Below are examples of allegations, alternative hypotheses, and possible ways of testing these hypotheses. *It's important that your test questions be case-specific and based on information received during the free narrative.*

### Sexual Abuse Allegation

A 9-year-old girl reported that her stepfather touched her private parts while getting her ready for bed.

#### Hypothesis/Allegation

The girl was sexually abused.

#### Possible Alternative Hypotheses

- The child does not like the stepfather and would prefer to live with her natural father.  
The stepfather has to administer topical medication to the child's privates at bedtime.

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## Test Questions

- "Tell me what happens when [name child calls stepfather] gets you ready for bed."  
"Is there something you like about spending time with [name child calls stepfather]? Is there something you don't like about spending time with [name child calls stepfather]?"  
"How do you get along with [name child calls stepfather]? How do you get along with your father?"
- "You said your parents are divorced. Who decided that you should live with your mom? Tell me about that."
- "What was your stepfather doing just before he touched you?" After a disclosure of touching.
- "Have you been to a doctor recently? Tell me about that."

## Sexual Abuse Allegation

The mother of a 5-year-old girl said that her daughter disclosed sexual abuse after returning from her father's house.

### Hypothesis/ Allegation

The girl was sexually abused by her father.

### Possible Alternative Hypotheses

The girl was led into making a false report by her mother, who questions her daughter after visits to her father's house.

- The mother misunderstood a comment the girl made about a sex abuse prevention video shown in school.

## Test Questions

- "Tell me about visiting Dad. Tell me some things you like about visiting Dad. Tell me some things you don't like about visiting Dad."  
"Tell me some things you like about your mom. Tell me some things you don't like about **you mom**."
- "What happens when you come home from Dad's house?"  
"Do you talk to your mom about your visit with Dad? Tell me about that."
- "Did you see a video at school about being safe? Tell me about the video. Did you tell your mom about the video? Did you tell your dad about the video?" If the answer is "Yes," explore with "What did you tell your mom (dad) about the video?" or "Tell me all about that."

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### **Child Recanting a Prior Abuse Allegation**

A 14-year-old boy claimed that his teacher touched him sexually (e.g., "He touched my butt!"). He later said his comment was an innocent mistake (e.g., "The hallway was crowded and he slid behind me to pass through the line).

#### **Hypothesis/Allegation**

The boy misspoke or exaggerated when he reported that his teacher had touched him sexually

#### **Possible Alternative Hypotheses**

- The child was touched inappropriately but is concerned that his teacher will be sent to prison.  
The child was touched inappropriately but is being teased by classmates and is embarrassed.
- The child got a bad grade and initially retaliated by lying about his teacher touching him.

#### **Test Questions**

"Tell me about your teacher."

"How do you get along with your teacher? Is there anything about this situation with your teacher that worries you?"

"Have any classmates talked to you about this situation with your teacher?" If the child says "Yes," the interviewer should explore further."

- "Have any friends or family members talked to you about this situation with your teacher?" If the child says "Yes," the interviewer should explore further.  
"Have you talked to someone else about your teacher since we last spoke?"

### **Physical Abuse Allegation**

A teacher reported that a 10-year-old boy came to school with a large bruise on the left side of his face. The child is secretive about the cause of the bruise.

#### **Hypothesis/ Allegation**

A parent abused the boy.

#### **Possible Alternative Hypotheses**

The injury was the result of an accident (e.g., The child was roughhousing with a sibling or injured while playing sports).

The child was involved in a fight that could get him in trouble and wants to avoid discipline.

The bruise was self-inflicted.

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## Test Questions

"I see you have a bruise on your face. Tell me how you got the bruise on your face."

"What were you doing just before you got the bruise on your face?"

"Who were you with when you got the bruise on your face?"

"How do you get along with your brothers/sisters?"

- "What happens at home when you get into trouble?"
- "What happens at school when you get into trouble?"

## Internet Sexual Exploitation Allegation

Police found sexually suggestive photographs of a 13-year-old girl on her father's computer.

### Hypothesis/ Allegation

The girl's father is taking pornographic pictures of his daughter and up-loading them onto the computer.

### Possible Alternative Hypotheses

- The girl took the pictures herself to send to her boyfriend.
- Someone other than the father took the photographs of the girl.

## Test Questions

"Who uses the computer in your house?"

"Do you have a camera? Who in your house has a camera?"

- "Do you have a boyfriend? Tell me about him."
- "Does anyone take pictures of you? Tell me about the pictures."
- "Have you ever seen these pictures? Where did you see them?"
- "Has anyone else taken pictures like this of you?"
- "Have you ever taken pictures like this of yourself?"

## Emotional Abuse Allegation

A teacher reported that the father of a 7-year-old yells at the boy almost every time he picks the child up from school. He makes demeaning comments to the boy, such as "I can't believe you are my son! I hate you!"

### Hypothesis/Allegation

The father is emotionally abusing the boy.

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### **Possible Alternative Hypotheses**

- The boy has a father and a step-father; it is the step-father who belittles the boy.  
The teacher had a previous altercation with the father and is embellishing the story.

### **Test Questions**

"Who lives with you? Tell me all the people in your family."

"Who usually picks you up from school? Tell me what happens when [person child named] picks you up from school."

"Tell me something you like about [person child named] picking you up from school. Tell me something you don't like about [person child named] picking you up from school."

- "Does your teacher talk about your father?"

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## Alternative Hypotheses Planning Form

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Hypothesis/ Allegation

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Possible Alternative Hypotheses

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Test Questions

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## Quick Guide #2: Guidelines for Questioning Children

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(Poole & Lamb, 1998. Adapted with permission from the American Psychological Association. For expanded discussions, see Walker, 1999.)

### Understanding the Child

If you cannot understand something the child said, ask the child to repeat the comment. Try not to guess with comments such as, "Did you say 'Bob?'"

- Children often make systematic pronunciation errors; for example, *potty* may sound like *body* or *something* may sound like *some paint*. Do not take young children's comments at face value; instead, always try to clarify what the child was saying by asking the child to describe the event fully (e.g., "I'm not sure I understand where he peed; tell me more about where he peed") or asking for an explicit clarification (e.g., "Did you say 'Bob' or 'mom' or something else?").
- When talking, use the usual adult pronunciation for words; do not mimic the child's speech or use baby-talk (Exception: Do use the child's words for body parts).
- The child's meaning for a word may not be the same as the adult's meaning. Some children use particular words in a more restrictive way (e.g., "bathing suits" or "pajamas" may not be clothing to a young child), a more inclusive way (e.g., "in" often means "in" or "between"), or in a way that is peculiar to them or their families (e.g., a "penis" is called a "bird"). Words that are critical to identifying an individual, event, or object should be clarified.
- Children may seem to contradict themselves because they use language differently than adults. For example, some children think that you only *touch* with your hands. Therefore, they may say "no" to questions such as "Did he touch you?" but later report that they were kissed. Children also tend to be very literal. For example, they might say "No" to the question "Did you put your mouth on his penis?" but later respond "Yes" to the question "Did he put his penis in your mouth?" Interviews may vary the phrasing of questions to check the child's understanding of the concept.

### Avoid Using Difficult Words or Introducing New Words

- Children under the age of about 7 years have difficulty with temporal words such as *before* and *after*. Try to narrow down the time of an event by asking about other activities or events, such as whether it was a school day or not a school day or what the child was doing that day.
- Young children are often confused by kinship terms (e.g., uncle, aunt). Instead of using the kinship term (e.g., "Tell me about your aunt"), refer to the person by name (e.g., "Tell me about Aunt Sue").
- Children sometimes confuse the meaning of word pairs such as "come" and "go," "here" and "there," and "a" and "the." This confusion can make it difficult for a child to understand a question such as "Did you go *there* for Christmas?" Whenever possible, it is best to ask questions that clearly mention

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specific places, people, objects and actions (e.g., "Did you go to Grandpa John's house on Christmas day, or did you go somewhere else?").

Even school-aged children often do not understand common legal terms and many other words that seem obvious to adults, such as *as judge, jury, or hearing*. Avoid legal terms or other adult jargon.

Children often integrate new words into their narratives, so avoid introducing key words, names, or phrases that the child has not yet volunteered.

### **Phrasing Questions**

Questions should ask about only one concept at a time. Avoid multiple questions.

Use a noun-verb-noun order. In other words, use the active voice (e.g., "You said earlier that you hit him ...") rather than the passive voice (e.g., "You said earlier that he was hit by you ...").

- Do not use "tag" questions such as "And then he left, didn't he?"

Words such as *she, he, that, or it* can be ambiguous to a child, even when these words are in the same sentence as their referents (e.g., "So when she came home, did mom take a nap?"). Be redundant and try to use the referent as often as possible (e.g., say, "So after *your father pushed you*, then what happened?" rather than "So after he did *that*, then what happened?").

Children learn to answer *who, what, and where* questions earlier than *when, how, and why* questions.

- Children's memory failures are more common when interviewers word questions specifically rather than broadly. For example, the question "Tell me about the last time you visited your cousin's *house*" is less likely to prompt recall of abuse in the *back yard* than the question "Tell me about the last time you visited your cousin."

### **Cultural Considerations**

If a child is from a different culture, the interviewer should try to confer with someone from that culture to see if special cultural considerations should be understood prior to the interview.

Children are discouraged in some cultures from looking authority figures in the eye while answering. Avoid correcting children's nonverbal behavior unless that behavior interferes with your ability to hear the child.

Interviewers should be aware that some cultural groups discourage children from correcting or contradicting an adult, and children from these environments may be more likely to answer multiple-choice or yes-no questions even when they are uncertain.

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## Quick Guide #3: Overview of a Phased Interview

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(Poole & Lamb, 1998. Adapted with permission from the American Psychological Association.)

### Prepare for the Interview

- Gather background information.  
Generate alternative hypotheses and hypothesis-testing questions.  
Remove distracting materials from the room.

### Introduce Yourself and Build Rapport: "Hello, my name is [interviewer's name]."

- Introduce yourself to the child by name and, if desired, by occupation.
- Explain the recording equipment, if used, and permit the child to glance around the room.  
Answer spontaneous questions from the child.

### Establish the Ground Rules: "Before we talk some more, I have some simple rules for talking today."

- Tell the child not to guess at an answer.
- Encourage the child to ask for clarification if the child does not understand something the interviewer said.
- Explain the child's responsibility to correct the interviewer when the interviewer is incorrect.  
Get a verbal agreement from the child to tell the truth.
- Allow the child to demonstrate understanding of the rules with practice questions (e.g., "What is my dog's name?").

### Conduct a Practice Interview: "I'd like to get to know you a little better now."

- Ask the child to recall a recent significant event or describe a scripted event (e.g., what does child do to get ready for school each morning or how child plays a favorite game).  
Tell the child to report everything about the event from beginning to end, even things that might not seem very important.
- Reinforce the child for talking by displaying interest both nonverbally and verbally (e.g., "Really?" or "Ohhh").

### Introduce the Topic: "Do you know the reason I came to talk with you?"

- Introduce the topic, starting with the least suggestive prompt.
- Avoid words such as "hurt", "bad", "good touch/bad touch", or "abuse".

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**Elicit a Free Narrative: "Tell me everything about [refer back to child's statement], even little things you don't think are very important."**

Prompt the child for a free narrative with general probes such as "Tell me everything you can about [refer back to child's statement]."

Encourage the child to continue, with open-ended prompts such as "Then what?" or "Tell me more about [event child described]."

**Question and Clarify: "I want to make sure I understand everything that happened."**

Cover topics in an order that builds upon the child's prior answers to avoid shifting topics during the interview.

Select less suggestive question forms over more suggestive questions as much as possible (See Quick Guide #4: Hierarchy of Interview Questions).

- Do not assume that the child's use of terms (e.g., "Uncle" or "pee pee") is the same as an adult's. Clarify important terms and descriptions of events that appear inconsistent, improbable, or ambiguous.
- Ask questions that will test alternative explanations for the allegations.

**Close the Interview: "Is there something else you'd like to tell me about [event child described]? Are there any questions you would like to ask?"**

- Ask if the child has any questions.
- Revert to neutral topics.
- Thank the child for coming.

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## Quick Guide #4: Hierarchy Of Interview Questions

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(Poole & Lamb, 1998. Adapted with permission from the American Psychological Association.)

This is a hierarchy of question types from least suggestive to most suggestive. **Whenever possible, select questions from the top of the hierarchy.**

### Free Narrative and Other Open-Ended Questions

Free-narrative questions are used after the topic has been introduced, to encourage children to describe events in *their own* words.

Examples:

- "Tell me everything about [event the child described]."  
"Stmnt with the first thing that happened and tell me everything, even things you don't think are very imp0ltant."

Open-ended questions allow children to select the specific details they will discuss. Open-ended questions encourage multiple-word responses.

Examples:

- "You said he took you into a room. Tell me about all of the things that were in that room."  
• "You said, 'That other time'. Tell me about that other time."

### Specific but Nonleading Questions

Specific but nonleading questions ask for details about topics that children have already mentioned. Use these questions only when the details are important, because children often try to answer specific questions even when they do not know the relevant information.

Examples:

- "What were you doing when Dad came over?"  
"What did your mom say after you told her?"

### Closed Questions

Closed questions, which provide only a limited number of options, are used when children do not respond to open-ended questions, when there is no obvious open-ended question that will elicit the desired information, or when a specific question is developmentally inappropriate. For example, the question "How many times did that happen?" is difficult for young children. Multiple-choice questions, paiticularly when they have more than two options, are preferable to yes-no questions because they permit a wider range of responses. Interviewers should try to follow closed questions with less directive prompts.

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Examples of multiple-choice questions:

- "Did [event] happen one time or more than one time?" Follow-up prompt: "Tell me about the last time [event] happened."
- "Did [event] happen at your house, at Grandpa's house, or some other place?" Follow-up prompt: "Tell me more about [location child described]."

Example of a yes-no question:

"Was your mom home when [event] happened?" Follow-up prompt: "Tell me what your mom was doing."

### **Explicitly Leading Questions**

Explicitly leading questions suggest the desired answer or contain information that the child has not yet volunteered. Even yes-no questions are considered leading by many psychologists, particularly if the child is young or the interviewer does not reiterate the child's right to say "No." Leading questions should be avoided during forensic interviews.

Examples of leading questions:

- "You told your mom you were scared of him, didn't you?"
- "What was he wearing when he laid next to you?" (when the child did not mention that the male in question laid down).

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## Quick Guide #5: Question Frames

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(Poole & Lamb, 1998. Adapted with permission from the American Psychological Association.)

Familiarity with a list of flexible question frames can help interviewers ask follow-up questions that are not leading.

### Elaboration

"You said [use child's words]. Tell me more."

"And then what happened?"

"Sometimes we know a lot about sounds or things that people said. Tell me all the things you heard when [use child's words]."

- "Sometimes we know a lot about how things looked. Tell me how everything looked when [use child's words]."

### Clarification

Object or action: "You said [use child's words]. Tell me what that is."

- Ambiguous person: "You said [Grandpa, teacher, Uncle Bill, etc.] Do you have one or more than one [Grandpa, teacher, Uncle Bill, etc.]?"
- "Does your [use child's words] have another name?" or "What does your [mom, dad, etc.] call [use child's words]?"

### Inconsistency

- "You said [child's first statement], but then you said [child's inconsistent statement]. I'm confused. Tell me again how that happened."  
"You said [child's first statement], but then you said [child's inconsistent statement]. Was that the same time or different times?"

### Repairing Conversational Breaks

"Tell me more."

"And then what happened?"

"You said [repeat child's last phrase before they stopped talking.] Then what happened?"

### Embarrassed Pause

"It's okay to say it."

- "It's okay to talk about this."

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**Repeated "I don't know" or "I don't remember" Answers**

- "It's okay to talk about this."
- "Is it you don't remember, or you don't want to talk about it?" If child says "Don't want to talk about it," ask, "Will something happen if you talk about it?"

**Inaudible Comment**

- "I couldn't hear you."
- "What did you say?"

**Single or Repeated Event**

- "Did it happen one time or more than one time?"  
If child says "Lots of times," respond, "Tell me about the *last* time something happened. I want to understand everything from the very beginning to the very end. Tell me about the *first* time. Tell me about the *worst* time. Tell me about *another time*."

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## Quick Guide #6: Guidelines for Use of Physical Evidence

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Physical evidence of abuse or neglect may be presented to a child during a forensic interview, if necessary. Attempts should first be made to introduce the topic and elicit a free narrative from the child without the use of physical evidence. If those attempts fail, the interviewer may choose to proceed using physical evidence to introduce the topic.

The use of physical evidence may also be helpful during the Question and Clarify phase. Interviewers should follow the hierarchy of questions, starting with the least suggestive types of questions (See Quick Guide #4: The Hierarchy of Interview Questions). For example, if a photograph is shown to a child, the interviewer should start by saying, "Tell me about this picture" rather than asking "What did he do to you?"

Types of physical evidence include, but are not limited to:

- Belts.
- Curling irons.
- Paddles.
- Medical photographs of bruises in physical abuse cases.  
Photographs of the condition inside a house in neglect cases.
- Sex toys.  
Camcorders.
- Lubricants in sexual abuse cases.
- Photographs or video recordings in sexual abuse cases.

The investigative team should consider several questions before making the decision whether or not to use physical evidence during the forensic interview:

- Is it necessary?
- When should the evidence be presented?
- How should the evidence be presented?
- Which items, images, or recordings should be presented to the child?
- Should the items, images, or recordings be masked to cover the abusive material?

Not all items, images, or recordings available may need to be presented to a child. Evidence presented during an interview should be chosen based upon issues including, but not limited to:

- Charging needs of the prosecutor.
- Identification of the child.  
Identification of the perpetrator(s).  
Identification of witnesses.
- Corroborative purposes.

After evaluating these questions, the team can then decide the most appropriate course of action.

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The interviewer should be up-front about physical evidence early in the interview. For example, with pictures, the interviewer might say "I have some pictures I may want to show you and talk about today, but first I want to get to know you better." This approach gives the interviewer the option of showing or not showing the physical evidence.

**Special consideration must be given to photographs or recordings of a child engaged in sexually abusive activity.** Please contact the charging authority (prosecutor or attorney general) in your area before presenting these types of images to a child. There are state and federal laws governing the possession and handling of child sexually abusive material. Child sexually abusive material should be handled by law enforcement. Law enforcement officers may provide child sexually abusive material to a forensic interviewer for use in a forensic interview if they ensure that the child sexually abusive material does not leave the interview location. All child sexually abusive material should be returned to law enforcement immediately after the interview.

The investigative team should consider using the least graphic images available. If necessary, the team may mask the images using paper, cardboard, tape, or a template to remove the abusive material. The method and nature of the masking should be documented.

Physical or digital evidence should not be altered. If it is impractical to mask the original and not alter the image, a copy may be made for this purpose. If a copy of an image (including a still frame from a video recording) needs to be made so that it can be masked, the investigative team should contact their local law enforcement digital evidence expert. Copies of child sexually abusive material for this purpose should only be made by a certified computer forensic examiner.

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## Quick Guide #7: Introduce the Topic

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This is a hierarchy of question types from open-ended to more directive. Whenever possible, select questions from the top of the hierarchy. Interviewers should start with an open-ended prompt that might raise the topic. Start with a transitional statement such as "Now that I know you a little better, it is time to talk about something else" and then follow-up with one or more of the following suggestions listed below.

**"Tell me the reason you are here today."**

**"Do you know the reason I came to talk with you?"**

**If answer is "I don't know," respond:**

"It is important for me to understand the reason you came to talk to me today."

"I talk to kids about things that have happened. Has something happened to you?"

"As I told you, my job is to talk to kids about things that have happened to them. It is very important that I understand the reason you are here. Tell me why you think your mom (dad, etc.) brought you here today."

- "Is your mom (dad, etc.) worried that something may have happened to you?" If the child says "Yes," respond, "Tell me what Mom (Dad, etc.) is worried about."

"Tell me the reason [person named in allegation] doesn't live with you anymore."

"I heard that someone has been bothering you. Tell me all about that."

"I heard that something might have happened to you. Tell me all about that."

**If children do not respond to any of the above, then questions can be more direct and focused:**

- "I heard you talked to [name of person] about something. Tell me all about that."
- "I heard that you saw a policeman (social worker, doctor, etc.) last week (yesterday.) Tell me all about that."
- "I have some information that something happened. Tell me all about what happened."

"Tell me all about [location or time of alleged incident]."

"I heard that someone might have [brief summary of allegation without mentioning name of alleged perpetrator]."

**Remember to follow up the answer with "Tell me all about [event child described]."**

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## Quick Guide #8: Physical Abuse and Neglect Questions

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This quick guide contains examples of questions which may be helpful during physical abuse and neglect interviews. As with any forensic interview, the interviewer should try to get as much information as possible from a child during the free narrative portion of the interview, using open-ended questions and prompts to elicit information from the child. Keep in mind the questions below are not a script, as case features and child responses determine which questions are appropriate. It is important to follow up on the child's answers with prompts such as "Tell me more about [use child's words]."

### **Child Was Left Home Alone (Failure to Supervise)**

- "Have you ever been left home alone? Tell me about being home alone."  
"Tell me about the last time you were home alone."  
"If you need help and your mom (dad) is not home, what do you do?"  
"Tell me how you feel when you are home alone."
- "Tell me what happened last night after your mom (dad) left the house."  
"I understand the police were at your home last night-tell me all about last night."

### **Child Is Not Taking Prescribed Medication/Pills (Medical Neglect)**

- "I understand that you take pills so you don't get sick. Tell me about that."  
"Tell me about the pills that you take."  
"Tell me what your pills look like."  
"How do you get your pills?"
- "Do you need help to take your pills?"  
"What happens if you don't take your pills?"
- "Has there ever been a time when you had no pills? Tell me about that time."
- "Was there a time you didn't take your pills-what happened?"

### **Child Is in a Dirty House or House Lacking Food, Heat, or Water (Neglect)**

- "What do you like about your house?"
- "Is there anything you do not like about your house?"  
"What happens when you get dirty?"
- "What happens when your clothes get dirty?"  
"Tell me about the last time you had a bath or shower."
- "Tell me about the food you ate today, beginning with when you got up this morning."  
"How do you stay warm in your house?"
- "Do you have any pets? Where does your pet go to the bathroom?"

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### **Child Has Been Spanked/Hit, Leaving Injury (Physical Abuse)**

- "Tell me the best thing about your family."
- "Is there anything about your family that you do not like? Tell me about the things you don't like."
- "Tell me what happens if you don't do what your mom (dad, mom's boyfriend/ girlfriend) tells you **to do.**"  
"What happens when your mom (dad) gets mad?"
- "You said that Mom hit you with a fly swatter. Tell me about that time with the fly swatter."  
"Tell me about the last time you were spanked (hit, kicked)."
- "Who else did you tell? Who else knows about this?"  
"You said your dad hit you with a belt. Tell me what your (arm, leg, etc.) looked like after your dad hit you with a belt."
- "I understand the police were at your house last night. Tell me about last night."

### **Child Has Been Ridiculed/Humiliated/Threatened Consistently (Emotional Abuse)**

- "Tell me the best thing about your family."  
"Is there something about your family that you do not like? Tell me about the things you don't like."
- "Tell me about the last time you were afraid."  
"If you could change three things about your family, what would you change?"
- "Tell me about the last time your mom (dad) was angry with you."  
"Tell me about the last time someone made you feel bad about yourself."
- "Tell me about the last time you felt like crying."  
"I heard that someone was calling you names. Tell me about the name calling."

### **Child Has Recanted**

- "Do you know the reason you are here today?"
- "You said [child's initial statement] then you said [child's second statement.] I'm confused. Help me understand."
- "Tell me what's been going on in your life since the last time we talked. How is your mom? How is your dad?" Use information you obtained in the first interview about likes/dislikes, family, etc. to try to determine what changes, if any, may have prompted a recantation.
- "Did someone tell you what to say today?"  
"Tell me the reason you're saying this today."
- "We talked a couple weeks ago. You told me [child's disclosure]. Tell me the reason you told me about [child's disclosure]."

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## Quick Guide #9: Sexual Abuse Questions

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This quick guide contains examples of questions which may be helpful during sexual abuse interviews. As with any forensic interview, the interviewer should try to get as much information as possible from a child during the free narrative portion of the interview, using open-ended questions and prompts to elicit information from the child. Keep in mind the questions below are not a script, as case features and child responses determine which questions are appropriate.

### Who is the alleged perpetrator?

- **Clearly identify the alleged perpetrator.** "Who did [child's report of what happened]? Who is [name child mentioned]?" Do not assume you understand what the child means. For example, if the child says "I came here to talk about what Daddy did," you can ask "Does daddy have another name?" or "Do you have one daddy or more than one daddy?"
- **Determine the child's relationship to the alleged perpetrator.** For example, "How do you know [name child used]?"

**What allegedly happened?** Determine what happened before, during, and after the event, putting the child's report in context. "Tell me what happened before [event child described]? Tell me what happened after [event child described]."

- **If the child reports touching, clarify what part of the alleged perpetrator's body was involved.** "How did [alleged perpetrator] touch you? You said he touched your pee pee. What part of his body touched your pee pee?" If child says "His hand," ask "Did some other part of his body touch your pee pee, or just his hand?"
- **Clarify whether the child is reporting touching on top of clothes or under clothes.** "What were you wearing? What was [alleged perpetrator] wearing? Did anything happen to your clothes? Did anything happen to [alleged perpetrator's] clothes? Did your clothes move at all? You said he touched your pee pee with his hand and you were wearing pajamas and panties. Was [alleged perpetrator's] hand on top of your pajamas or under your pajamas?" If child reports under pajamas, ask "Was his hand on top of your panties, on your skin, or somewhere else?"

If the child is young, you can begin this line of questioning by testing knowledge of "on top of" and "under" using props, such as a piece of paper and a pencil. "I want to make sure I understand your words. Put the pencil on top of the paper. Put the pencil under the paper."

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- **Determine if the child is alleging any degree of penetration, e.g., outside genital region or inside labia majora.** "You said [alleged perpetrator] [child's report, i.e., touched, felt, etc.] your [child's word] with his hand." Determine child's name for body part and have child point to it; ask "Can you point to your [child's word]?" If a girl points to genital area, ask "What do you do with your [child's word, i.e. private, kitty cat, coochie, etc.]? After you go pee pee (or whatever word child used), what do you do?" If child says, "I wipe myself", ask "The area where you wipe yourself - what do you call it? You said that [alleged perpetrator] touched your [child's word]. Did [alleged perpetrator] touch on the outside of [child's word] or inside where you wipe yourself? How did it feel when [alleged perpetrator] [child's report]?"

If the child is young, you can begin this line of questioning by testing knowledge of "inside" and "outside" using props, such as a pencil box and a pencil. "Let me make sure I understand your words. Put the pencil outside the box. Put the pencil inside the box."

- **Determine if there may be physical evidence on clothing (e.g., ejaculate, creams) or items that can be retrieved.** "Tell me everything that happened when [alleged perpetrator] [child's report]. Did [alleged perpetrator] use anything when he touched you? What did the [item child mentioned] look like? Where is the [item child mentioned] kept?" If the child alleges penile contact, ask "What did his [child's word for penis] look like? Did anything come out of [child's word for penis]? What did [alleged perpetrator] do about [child's word for what came out of penis]?"
- **Ask about conversation.** "Did [alleged perpetrator] say anything? Did you say anything (talk) to [alleged perpetrator]? When [abuse] ended, did [alleged perpetrator] say something?"
- **Ask about potential witnesses.** "Was anyone else there when [alleged perpetrator] [child's report]? Did anyone see? Did you hear anyone else? Did anyone hear you?"

**Where did this allegedly happen?** "Where were you when [alleged perpetrator] [child's report]." If reported location is a home or apartment, ask "What room were you in when [alleged perpetrator] [child's report]? Tell me what [child's word for room] looks like. Where were you in the [child's word for room]?"

**When did this allegedly happen?** For younger children, use questions about age, school, or recent holidays to restrict the time; e.g., "How old were you when [alleged perpetrator] [child's report]? What grade in school were you in when [alleged perpetrator] [child's report]? Did [alleged perpetrator] [child's report] a short time ago or a long time ago?" For older children, ask "When did this happen?" Attempt to establish whether offenses happened after August 2006 (when the law was amended to increase penalties). For younger children, if you need to determine a time of day for the alleged event, ask questions about what they were doing, using school hours, television shows, or mealtimes to narrow the time; e.g., "What were you doing when [alleged perpetrator] started to [child's report]" (See Questions about Time on page 22).

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**How often did this allegedly happen?** Ask questions about the nature of the touching for each event the child reports.

- Young child: "Did [alleged perpetrator] [child's report] one time or more than one time?" If child says, "More than one time", ask "Did [child's report] happen a lot of times or just a few times?"
- "Tell me about the first time [alleged perpetrator] [child's report]. Tell me about the last time [alleged perpetrator] [child's report]. You told me [alleged perpetrator] [child's first report] and [second report]. Were those the only times or was there another time? What time do you remember the best? What was the worst time something like [child's report] happened?"

It is not necessary to ask the child for the specific number of times the abuse happened. Instead, determine if it happened every day, once a week, every time Mom went bowling, every time the alleged perpetrator babysat, or in reference to some other meaningful event.

**Were images taken or were sexually explicit materials used?**

"Did [alleged perpetrator] show you anything when [child's report] happened? Tell me about the [child's report]."

"Did [alleged perpetrator] ever show you any books, pictures, or movies when [report of abuse] happened? Tell me everything about [child's report]."

"Did [alleged perpetrator] say something about books, pictures, or movies when [report of abuse] happened? Tell me all about [what accused said]."

"Did [alleged perpetrator] have a computer, cell phone or other media device? Did [alleged perpetrator] show you anything on [named media device]? Tell me about [child's report]."

- "Did [alleged perpetrator] show you anything on the TV or [named media device] that you think children your age shouldn't see?" Ask questions to find out where these items are located in the house and what the child saw.

"Did you ever watch movies with [alleged perpetrator]?"

- "Did [alleged perpetrator] take any pictures? How do you know? Tell me all about [child's report]."

**Who knows about the alleged abuse?**

- **Identify people the child has told and when these disclosures occurred.** "Have you told someone about [child's report]? Does anyone else know about [child's report]? How long has [named person] known about [allegation]?"

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- **Explore the child's motivations for delaying disclosure.** "Did you tell someone?" If the child responds "No" then follow up with "Is there a reason you didn't tell?" If the child responds "Yes", then "Is there a reason you decided to tell? How was [child's report] able to stay a secret for so long? Did [alleged perpetrator] say something about you telling? Did [alleged perpetrator] give you anything? Did [alleged perpetrator] take away anything from you? Is there anything [alleged perpetrator] allows you to do, that you can't do somewhere else? Did [alleged perpetrator] let you break any of your mom or dad's rules?"
  - **Ask if other people know about the alleged events.** "Who else knows about [child's report]? How do they know? Did someone else see (hear) this?" Remember that preschoolers may have difficulty with questions that include the words "remember" and "know."

**What was the nature/quality of the child's relationship with the alleged perpetrator?** Explore the alleged perpetrator's relationship with the child to elicit details of grooming (e.g., unusual gift-giving) or motivations for the child to lie (e.g., history of harsh punishment or rules). "How did you get along with [alleged perpetrator]? Is there something you liked about spending time with [alleged perpetrator]? Is there something you didn't like about spending time with [alleged perpetrator]? How did you feel about [alleged perpetrator] when he wasn't [child's report]? Were there other things you didn't like about spending time with [alleged perpetrator]? How did your mom (dad, brother, etc.) get along with [alleged perpetrator]?"

**Has the alleged perpetrator allegedly done this to someone else?** "Has [alleged perpetrator] done things he shouldn't do to another child? Have you seen with your own eyes...or...Have you seen [alleged perpetrator] do it to another child?" Follow up with questions to determine the child's name, name of parents, if known, and "Does your mom or dad know how to reach them?"

**Has someone else allegedly done this to the child?** "Has someone else ever [child's report]?" If the child mentions a name, begin a line of questioning to clarify who that individual is and to explore this new disclosure.

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## End Notes

'A variety of terms are used to describe this progression from introduction to closing, including *step-wise* (Yuille, Hunter, Joffe, & Zaparniuk, 1993), *funnel* (Sternberg *et al.*, 2002), and *phased approaches* (Bull, 1995).

There are no fixed guidelines about how much information interviewers should gather before meeting with a child. An interview is conducted "blind" when the interviewer knows only the child's name and age. The goal of a blind interview is to reduce the possibility that the interviewer can direct the child to confirm the allegations by asking specific or leading questions. There are a variety of reasons why most experts oppose blind interviews. First, it is difficult for interviewers to develop rapport with children when they know nothing about their living situations or interests. Second, because some children will not respond to general questions about why they are being interviewed, it is difficult for interviewers to introduce the topic of abuse when they know nothing about the place or timing of the alleged abuse. Third, blind interviewing makes it more difficult for interviewers to consider alternative hypotheses about the meaning of children's statements. Information about recent medical treatment, adults in a child's life who have duplicate names (e.g., two grandpas), and the child's caretaking environments and playmates can help interviewers understand what a child is describing. For these reasons, the National Center for Prosecution of Child Abuse, the American Prosecutor's Research Institute, and the National District Attorney's Association (1993, p. 59) concluded, "Interviewing a child without knowing any of the details revealed to another is analogous to performing a medical examination without knowing the patient's history or looking for an unfamiliar destination without a road map."

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## Appendix Videorecording Laws

For the most current version of these laws, refer to: [www.legislature.mi.gov](http://www.legislature.mi.gov).

### Criminal Statute

**MCLA 600.2163a Definitions; prosecutions and proceedings to which section applicable; use of dolls or mannequins; support person; notice; videorecorded statement; special arrangements to protect welfare of witness; videotape deposition; section additional to other protections or procedures; violation as misdemeanor; penalty.**

Sec.2163a. (1) As used in this section:

(a) "Custodian of the videorecorded statement" means the family independence agency, investigating law enforcement agency, prosecuting attorney, or department of attorney general or another person designated under the county protocols established as required by section 8 of the child protection law, 1975 PA 238, MCL 722.628.

(b) "Developmental disability" means that term as defined in section 100a of the mental health code, 1974 PA 258, MCL 330.110a, except that, for the purposes of implementing this section, developmental disability includes only a condition that is attributable to a mental impairment or to a combination of mental and physical impairments and does not include a condition attributable to a physical impairment unaccompanied by a mental impairment.

(c) "Videorecorded statement" means a witness's statement taken by a custodian of the videorecorded statement as provided in subsection (5). Videorecorded statement does not include a videorecorded deposition taken as provided in subsections (17) and (18).

(d) "Witness" means an alleged victim of an offense listed under subsection (2) who is either of the following:

(i) A person under 16 years of age.

(ii) A person 16 years of age or older with a developmental disability.

(2) This section only applies to prosecutions and proceedings under section 136b, 145c, 520b to 520e, or 520g of the Michigan penal code, 1931 PA 328, MCL 750.136b, 750.145c, 750.520b to 750.520e, and 750.520g, or under former section 136 or 136a of the Michigan penal code, 1931 PA 328.

(3) If pertinent, the witness shall be permitted the use of dolls or mannequins, including, but not limited to, anatomically correct dolls or mannequins, to assist the witness in testifying on direct and cross-examination.

(4) A witness who is called upon to testify shall be permitted to have a support person sit with, accompany, or be in close proximity to the witness during his or her testimony. A notice of intent to use a support person shall name the support person, identify the relationship the support person has with the witness, and give notice to all parties to the proceeding that the witness may request that the named support person sit with the witness when the witness is called upon to testify during any stage of the proceeding. The notice of intent to use a named support person shall be filed with the court and shall be served upon all parties to the proceeding. The court shall rule on a motion objecting to the use of a named support person before the date at which the witness desires to use the support person.

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- (5) A custodian of the videorecorded statement may take a witness's videorecorded statement before the normally scheduled date for the defendant's preliminary examination. The videorecorded statement shall state the date and time that the statement was taken; shall identify the persons present in the room and state whether they were present for the entire videorecording or only a portion of the videorecording; and shall show a time clock that is running during the taking of the videorecorded statement.
- (6) A videorecorded statement may be considered in court proceedings only for 1 or more of the following:
- (a) It may be admitted as evidence at all pretrial proceedings, except that it may not be introduced at the preliminary examination instead of the live testimony of the witness.
  - (b) It may be admitted for impeachment purposes.
  - (c) It may be considered by the court in determining the sentence.
  - (d) It may be used as a factual basis for a no contest plea or to supplement a guilty plea.
- (7) In a videorecorded statement, the questioning of the witness should be full and complete; shall be in accordance with the forensic interview protocol implemented as required by section 8 of the child protection law, 1975 PA 238, MCL 722.628; and, if appropriate for the witness's developmental level, shall include, but is not limited to, all of the following areas:
- (a) The time and date of the alleged offense or offenses.
  - (b) The location and area of the alleged offense or offenses.
  - (c) The relationship, if any, between the witness and the accused.
  - (d) The details of the offense or offenses.
  - (e) The names of any other persons known to the witness who may have personal knowledge of the alleged offense or offenses.
- (8) A custodian of the videorecorded statement may release or consent to the release or use of a videorecorded statement or copies of a videorecorded statement to a law enforcement agency, an agency authorized to prosecute the criminal case to which the videorecorded statement relates, or an entity that is part of county protocols established under section 8 of the child protection law, 1975 PA 238, MCL 722.628. The defendant and, if represented, his or her attorney has the right to view and hear a videorecorded statement before the defendant's preliminary examination. Upon request, the prosecuting attorney shall provide the defendant and, if represented, his or her attorney with reasonable access and means to view and hear the videorecorded statement at a reasonable time before the defendant's pretrial or trial of the case. In preparation for a court proceeding and under protective conditions, including, but not limited to, a prohibition on the copying, release, display, or circulation of the videorecorded statement, the court may order that a copy of the videorecorded statement be given to the defense.
- (9) If authorized by the prosecuting attorney in the county in which the videorecorded statement was taken, a videorecorded statement may be used for purposes of training the custodians of the videorecorded statement in that county on the forensic interview protocol implemented as required by section 8 of the child protection law, 1975 PA 238, MCL 722.628.
- (10) Except as provided in this section, an individual, including, but not limited to, a custodian of the videorecorded statement, the witness, or the witness's parent, guardian, guardian ad litem, or attorney, shall not release or consent to release a videorecorded statement or a copy of a videorecorded statements.
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(11) A videorecorded statement that becomes part of the court record is subject to a protective order of the court for the purpose of protecting the privacy of the witness.

(12) A videorecorded statement shall not be copied or reproduced in any manner except as provided in this section. A videorecorded statement is exempt from disclosure under the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246, is not subject to release under another statute, and is not subject to disclosure under the Michigan court rules governing discovery. This section does not prohibit the production or release of a transcript of a videorecorded statement.

(13) If, upon the motion of a party made before the preliminary examination, the court finds on the record that the special arrangements specified in subsection (14) are necessary to protect the welfare of the witness, the court shall order those special arrangements. In determining whether it is necessary to protect the welfare of the witness, the court shall consider all of the following:

(a) The age of the witness.

(b) The nature of the offense or offenses.

(c) The desire of the witness or the witness's family or guardian to have the testimony taken in a room closed to the public.

(14) If the court determines on the record that it is necessary to protect the welfare of the witness and grants the motion made under subsection (13), the court shall order both of the following:

(a) All persons not necessary to the proceeding shall be excluded during the witness's testimony from the courtroom where the preliminary examination is held. Upon request by any person and the payment of the appropriate fees, a transcript of the witness's testimony shall be made available.

(b) In order to protect the witness from directly viewing the defendant, the courtroom shall be arranged so that the defendant is seated as far from the witness stand as is reasonable and not directly in front of the witness stand. The defendant's position shall be located so as to allow the defendant to hear and see the witness and be able to communicate with his or her attorney.

(15) If upon the motion of a party made before trial the court finds on the record that the special arrangements specified in subsection (16) are necessary to protect the welfare of the witness, the court shall order those special arrangements. In determining whether it is necessary to protect the welfare of the witness, the court shall consider all of the following:

(a) The age of the witness.

(b) The nature of the offense or offenses.

(c) The desire of the witness or the witness's family or guardian to have the testimony taken in a room closed to the public.

(16) If the court determines on the record that it is necessary to protect the welfare of the witness and grants the motion made under subsection (15), the court shall order 1 or more of the following:

(a) All persons not necessary to the proceeding shall be excluded during the witness's testimony from the courtroom where the trial is held. The witness's testimony shall be broadcast by closed-circuit television to the public in another location out of sight of the witness.

(b) In order to protect the witness from directly viewing the defendant, the courtroom shall be arranged so that the defendant is seated as far from the witness stand as is reasonable and not directly in front of the witness stand. The defendant's position shall be the same for all witnesses and shall be located so as to allow the defendant to hear and see all witnesses and be able to communicate with his or her attorney.

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(c) A questioner's stand or podium shall be used for all questioning of all witnesses by all parties and shall be located in front of the witness stand.

(17) If, upon the motion of a party or in the court's discretion, the court finds on the record that the witness is or will be psychologically or emotionally unable to testify at a court proceeding even with the benefit of the protections afforded the witness in subsections (3), (4), (14), and (16), the court shall order that a videorecorded deposition of a witness shall be taken to be admitted at a court proceeding instead of the witness's live testimony.

(18) For purpose of the videorecorded deposition under subsection (17), the witness's examination and cross-examination shall proceed in the same manner as if the witness testified at the court proceeding for which the videorecorded deposition is to be used, and the court shall order that the witness, during his or her testimony, shall not be confronted by the defendant but shall permit the defendant to hear the testimony of the witness and to consult with his or her attorney.

(19) This section is in addition to other protections or procedures afforded to a witness by law or court rule.

(20) A person who intentionally releases a videorecorded statement in violation of this section is guilty of a misdemeanor punishable by imprisonment for not more than 93 days or a fine of not more than \$500.00, or both.

**History:** Add. 1987, Act 44, Eff. Jan. 1, 1988;--Am. 1989, Act 253, Eff. Mar. 29, 1990;--Am. 1998, Act 324, Imd. Eff. Aug. 3, 1998;--Am. 2002, Act 604, Eff. Mar. 31, 2003.

### **Probate Code Statute**

**MCL 712A.17b Definitions; proceedings to which section applicable; use of dolls or mannequins; support person; notice; videorecorded statement; shielding of witness; videorecorded deposition; special arrangements to protect welfare of witness; section additional to other protections or procedures.**

Sec. 17b. (1) As used in this section:

(a) "Custodian of the videorecorded statement" means the family independence agency, investigating law enforcement agency, prosecuting attorney, or department of attorney general or another person designated under the county protocols established as required by section 8 of the child protection law, 1975 PA 238, MCL 722.628.

(b) "Developmental disability" means that term as defined in section 100a of the mental health code, 1974 PA 258, MCL 330.100a, except that, for the purposes of implementing this section, developmental disability includes only a condition that is attributable to a mental impairment or to a combination of mental and physical impairments, and does not include a condition attributable to a physical impairment unaccompanied by a mental impairment.

(c) "Videorecorded statement" means a witness's statement taken by a custodian of the videorecorded statement as provided in subsection (5). Videorecorded statement does not include a videorecorded deposition taken as provided in subsections (16) and (17).

(d) "Witness" means an alleged victim of an offense listed under subsection (2) who is either of the following:

(i) A person under 16 years of age.

(ii) A person 16 years of age or older with a developmental disability.

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(2) this section only applies to either of the following:

(a) A proceeding brought under section 2(a)(1) of this chapter in which the alleged offense, if committed by an adult, would be a felony under section 136b, 145c, 520b to 520e, or 520g of the Michigan penal code, 1931PA 328, MCL 750.136b, 750.145c, 750.520b to 750.520e, and 750.520g, or under former section 136 or 136a of the Michigan penal code, 1931PA 328.

(b) A proceeding brought under section 2(b) of this chapter.

(3) If pertinent, the witness shall be permitted the use of dolls or mannequins, including, but not limited to, anatomically correct dolls or mannequins, to assist the witness in testifying on direct and cross-examination.

(4) A witness who is called upon to testify shall be permitted to have a support person sit with, accompany, or be in close proximity to the witness during his or her testimony. A notice of intent to use a support person shall name the support person, identify the relationship the support person has with the witness, and give notice to all parties to the proceeding that the witness may request that the named support person sit with the witness when the witness is called upon to testify during any stage of the proceeding. The notice of intent to use a named support person shall be filed with the court and shall be served upon all parties to the proceeding. The court shall rule on a motion objecting to the use of a named support person before the date at which the witness desires to use the support person.

(5) A custodian of the videorecorded statement may take a witness's videorecorded statement. The videorecorded statement shall be admitted at all proceedings except the adjudication stage instead of the live testimony of the witness. The videorecorded statement shall state the date and time that the statement was taken; shall identify the persons present in the room and state whether they were present for the entire videorecording or only a portion of the videorecording; and shall show a time clock that is running during the taking of the statement.

(6) In a videorecorded statement, the questioning of the witness should be full and complete; shall be in accordance with the forensic interview protocol implemented as required by section 8 of the child protection law, 1975 PA 238, MCL 722.628; and, if appropriate for the witness's developmental level, shall include, but need not be limited to, all of the following areas:

(a) The time and date of the alleged offense or offenses.

(b) The location and area of the alleged offense or offenses.

(c) The relationship, if any, between the witness and the respondent.

(d) The details of the offense or offenses.

(e) The names of other persons known to the witness who may have personal knowledge of the offense or offenses.

(7) A custodian of the videorecorded statement may release or consent to the release or use of a videorecorded statement or copies of a videorecorded statement to a law enforcement agency, an agency authorized to prosecute the criminal case to which the videorecorded statement relates, or an entity that is part of county protocols established under section 8 of the child protection law, 1975 PA 238, MCL 722.628. Each respondent and, if represented, his or her attorney has the right to view and hear the videorecorded statement at a reasonable time before it is offered into evidence. In preparation for a court proceeding and under protective conditions, including, but not limited to, a prohibition on the copying, release, display, or circulation of the videorecorded statement, the court may order that a copy of the videorecorded statement be given to the defense.

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(8) If authorized by the prosecuting attorney in the county in which the videorecorded statement was taken, a videorecorded statement may be used for purposes of training the custodians of the videorecorded statement in that county on the forensic interview protocol implemented as required by section 8 of the child protection law, 1975 PA 238, MCL 722.628.

(9) Except as provided in this section, an individual, including, but not limited to, a custodian of the videorecorded statement, the witness, or the witness's parent, guardian, guardian ad litem, or attorney, shall not release or consent to release a videorecorded statement or a copy of a videorecorded statement.

(10) A videorecorded statement that becomes part of the court record is subject to a protective order of the court for the purpose of protecting the privacy of the witness.

(11) A videorecorded statement shall not be copied or reproduced in any manner except as provided in this section. A videorecorded statement is exempt from disclosure under the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246, is not subject to release under another statute, and is not subject to disclosure under the Michigan court rules governing discovery. This section does not prohibit the production or release of a transcript of a videorecorded statement.

(12) Except as otherwise provided in subsection (15), if, upon the motion of a party or in the court's discretion, the court finds on the record that psychological harm to the witness would occur if the witness were to testify in the presence of the respondent at a court proceeding or in a videorecorded deposition taken as provided in subsection (13), the court shall order that the witness during his or her testimony be shielded from viewing the respondent in such a manner as to enable the respondent to consult with his or her attorney and to see and hear the testimony of the witness without the witness being able to see the respondent.

(13) In a proceeding brought under section 2(b) of this chapter, if, upon the motion of a party or in the court's discretion, the court finds on the record that psychological harm to the witness would occur if the witness were to testify at the adjudication stage, the court shall order to be taken a videorecorded deposition of a witness that shall be admitted into evidence at the adjudication stage instead of the live testimony of the witness. The examination and cross-examination of the witness in the videorecorded deposition shall proceed in the same manner as permitted at the adjudication stage.

(14) In a proceeding brought under section 2(a)(1) of this chapter in which the alleged offense, if committed by an adult, would be a felony under section 136b, 145c, 520b to 520e, or 520g of the Michigan penal code, 1931 PA 328, MCL 750.136b, 750.145c, 750.520b to 750.520e, and 750.520g, or under former section 136 or 136a of the Michigan penal code, 1931 PA 328, if, upon the motion of a party made before the adjudication stage, the court finds on the record that the special arrangements specified in subsection (15) are necessary to protect the welfare of the witness, the court shall order 1 or both of those special arrangements. In determining whether it is necessary to protect the welfare of the witness, the court shall consider both of the following:

(a) The age of the witness.

(b) the nature of the offense or offenses.

(15) If the court determines on the record that it is necessary to protect the welfare of the witness and grants the motion made under subsection (14), the court shall order 1 or both of the following:

(a) In order to protect the witness from directly viewing the respondent, the courtroom shall be arranged so that the respondent is seated as far from the witness stand as is reasonable and not

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directly in front of the witness stand. The respondent's position shall be located so as to allow the respondent to hear and see all witnesses and be able to communicate with his or her attorney.

(b) A questioner's stand or podium shall be used for all questioning of all witnesses by all parties, and shall be located in front of the witness stand.

(16) In a proceeding brought under section 2(a)(1) of this chapter in which the alleged offense, if committed by an adult, would be a felony under section 136b, 145c, 52ob to 52oe, or 52og of the Michigan penal code, 1931PA 328, MCL 750.136b, 750.145c, 750.52ob to 750.52oe, and 750.52og, or under former section 136 or 136a of the Michigan penal code, 1931PA 328, if, upon the motion of a party or in the court's discretion, the court finds on the record that the witness is or will be psychologically or emotionally unable to testify at a court proceeding even with the benefit of the protections afforded the witness in subsections (3), (4), and (15), the court shall order that a videorecorded deposition of a witness shall be taken to be admitted at the adjudication stage instead of the witness's live testimony.

(17) For purposes of the videorecorded deposition under subsection (16), the witness's examination and cross-examination shall proceed in the same manner as if the witness testified at the adjudication stage, and the court shall order that the witness, during his or her testimony, shall not be confronted by the respondent but shall permit the respondent to hear the testimony of the witness and to consult with his or her attorney.

(18) This section is in addition to other protections or procedures afforded to a witness by law or court rule.

(19) A person who intentionally releases a videorecorded statement in violation of this section is guilty of a misdemeanor punishable by imprisonment for not more than 93 days or a fine of not more than \$500.00, or both.

**History:** Add. 1987, Act 45, Eff. Jan. 1, 1988;--Am. 1989, Act 254, Eff. Mar. 29, 1990;--Am. 1998, Act 325, Imd. Eff. Aug. 3, 1998;--Am. 2002, Act 625, Eff. Mar. 31, 2003.

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QUANTITY: 5,000  
COST: \$7,894.37 (\$1.57 ea.)  
AUTHORITY: DHS DIRECTOR

Department of Human Services (OHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a OHS office in your area.

A ppendix

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STATE OF MICHIGAN

GOVERNOR'S TASK FORCE ON CHILD ABUSE AND NEGLECT

**Medical Child Abuse**

**A Collaborative Approach  
to Identification, Investigation,  
Assessment and Intervention**

GOVERNOR'S TASK FORCE ON CHILD ABUSE AND NEGLECT

## CURRENT TASK FORCE MEMBERS

### **The Honorable Justice Elizabeth A. Weaver**

Retired Justice, Michigan Supreme Court  
Chair of The Task Force

#### **Daniel Adams**

Detective  
Grand Rapids Police Department  
Kent County

#### **John Ange**

Assistant Prosecuting Attorney  
Chief, Juvenile Division  
Macomb County Prosecutor's Office

#### **Wayne Beerbower**

Police Officers Association of Michigan  
Retired Farmington Hills Police Officer  
Oakland County

#### **Jeanie Colella**

vice President, Board of Directors  
Michigan CASA, Inc.  
Ottawa County

#### **The Honorable Maura D. Corrigan**

Director  
Department of Human Services  
Retired Justice, Michigan Supreme Court

#### **Nancy J. Diehl**

Retired Assistant Prosecuting Attorney  
Chief, Trial Division  
Wayne County Prosecutor's Office

#### **The Honorable Susan L. Dobrich**

Judge, Probate Court  
Cass County

#### **The Honorable Judy Hartsfield**

Judge, Probate Court  
Wayne County

#### **Shauna Dunnings**

Attorney and Deputy Court Administrator  
Ingham County Friend of the Court

#### **Elias Escobedo**

Attorney, Criminal Defense and Family Law  
Oakland County

#### **Cheryl Follette**

Attorney/Guardian Ad Litem  
Child Abuse and Domestic Cases  
Grand Traverse County

#### **Euphemia "Sue" Franklin**

Executive Director  
South Eastern Michigan Indians, Inc.  
Wayne County

#### **The Honorable JoAnne Gasco**

Judge, Little Traverse Bay Bands  
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## MEDICAL CHILD ABUSE

### A COLLABORATIVE APPROACH TO IDENTIFICATION, INVESTIGATION, ASSESSMENT **AND** INTERVENTION

#### PART ONE

#### INTRODUCTION

The purpose of this publication is to present an updated multidisciplinary approach that guides various professionals through the identification, investigation, and assessment of and intervention in cases involving suspected Medical Child Abuse<sup>1</sup> (MCA). This term is used to describe a form of child abuse in which a child receives unnecessary and harmful, or potentially harmful, medical care at the instigation of the child's parent or other caretaker. A parent/caretaker may exaggerate, fabricate (lie about), or cause symptoms of illness that will lead to unnecessary medical treatment of the child. Parents/caretakers may present with a convincing but deceptive medical history that persuades medical professionals to provide unnecessary medical interventions. Thus, medical providers may become unwitting instruments of the abuse by performing unnecessary surgeries, diagnostic procedures, and other medical treatments based upon the parent/caretaker's false or exaggerated reports. Medical Child Abuse is a diagnosis recognized and supported by the American Board of Pediatrics.

The impact of Medical Child Abuse on the child who is the victim of it may include physical and psychological harm. Children who are victims may experience the deterioration of an existing medical condition because of deliberately neglected treatment for a genuine illness or may acquire medical problems after invasive diagnostic procedures and/or surgeries. All of these children suffer harm; some may suffer significant long-term harm or permanent disability from their maltreatment; some children die.

The psychological mechanisms that cause a parent/caretaker to harm a child in this way are not a factor when making a diagnosis of Medical Child Abuse, but may need to be considered when deciding about interventions (i.e. removal of the child, termination of parental rights, or reunification of the family).

Many cases of Medical Child Abuse go undetected because caregivers are skilled at deceiving the medical community. Accordingly, the coordination and collaboration of several disciplines and agencies is essential for identifying and responding to cases of suspected Medical Child Abuse. Each discipline should approach these cases from its own area of expertise with the common goal of ensuring the safety of children who are victims. This publication describes the role of each discipline and the manner in which the various professions should coordinate and interact. It is organized chronologically, using the time frame common to the detection and management of these cases.

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<sup>1</sup> Previously known as Munchausen By Proxy Abuse, Pediatric Condition Falsification and Factitious Disorder by Proxy.

Identifying and responding to this complex form of child abuse requires a carefully coordinated multidisciplinary intervention. This document is not a substitute for professionals' knowledge of Medical Child Abuse from the perspective of their disciplines. Rather, this publication is meant to serve an integrative and coordinating function to help professionals understand their roles. Coordination and collaboration by several disciplines and agencies is essential for identifying and responding to cases of suspected Medical Child Abuse with the common goal of ensuring the safety of the child victims. A list of selected references is included at the end of this document.

## PART TWO

### IDENTIFICATION

A primary medical provider is typically in the best position to initially detect and report suspected MCA. However, family members, neighbors, teachers and others may also report concerns related to abnormal/excessive medical care to Children's Protective Services (CPS). Detection is difficult and dependent on recognition of the warning signs that should trigger suspicion.

#### **WARNING SIGNS OF MEDICAL CHILD ABUSE**

The warning signs listed below are not diagnostic on their own and are not necessarily exclusive to Medical Child Abuse. However, when several warning signs exist, the primary medical provider is responsible for recognizing that the child may be at risk of harm and needs to consider the possibility of MCA. The warning signs include the following:

- There is a continuing discrepancy between the medical history of the child provided by the parent/caretaker and the medical provider's clinical assessment of the child.

A child who has one or more persistent and unexplained medical problems that do not respond to standard treatment.

There are physical or laboratory findings which are unusual, inconsistent with history, or clinically impossible.

A highly attentive parent/caretaker is unusually reluctant to leave his/her child's side.

- A parent/caretaker appears to thrive on the attention given to the child's lack of response to medical treatment.

A parent/caretaker who appears to be abnormally calm in the face of complications in the child's medical course.

A parent/caretaker who insists that the medical provider do more invasive procedures, demands second and third opinions, and gets angry when demands are not met.

A parent/caretaker is not relieved or reassured when presented with negative test results and resists having the child discharged from the hospital.

- The parent/caretaker may work in health care or have unusually detailed medical knowledge.

The signs and symptoms of a child's illness do not occur in the parent/caretaker's absence or are not witnessed by other individuals such as medical providers, family members, friends, teachers, etc.

The child has extended absences from school despite reassurance that the child can return to normal activity.

- There is a family history of other children with similar unexplained illness or death of a sibling.

A parent/caretaker gives a history of having symptoms similar to the child's illness.

When a medical provider, or other person, recognizes that the child may be a victim of Medical Child Abuse and is at risk of harm, a report should be made with CPS by calling (855) 444-3911.

If a medical provider is uncertain whether to file a report with CPS and would like to discuss concerns about a patient or family, the provider may contact the regional Michigan Department of Human Services Medical Resource System (MRS) provider. See Appendix A The medical provider and MRS personnel can discuss the medical provider's concerns and MRS personnel can assist the medical provider in understanding Medical Child Abuse.

Reviews of medical records concerning Medical Child Abuse are not a part of the DHS Medical Resource System contract; however, MRS personnel will facilitate the review of medical records in such cases.

The review of medical records cannot occur until a report is filed with CPS and a request for review of the records is initiated. The Health Insurance Portability and Accountability Act (HIPAA) regulations require CPS involvement prior to review of a child's medical records without parental consent.

Upon initiation of the review of medical records, a meeting involving the CPS reporting source (if a medical provider), the child's primary care provider, CPS, and the reviewer is strongly recommended. This meeting will serve to clearly define the concerns that generated a suspicion of Medical Child Abuse, the means by which the safety of the child will be ensured by CPS, the interventions planned by medical providers, the party providing the comprehensive record review, and a time frame for completion of the record review.

This process may occur on an outpatient basis while the child remains in the custody of the caregiver if CPS and medical personnel are satisfied that the safety of the child has been properly addressed.

**Key questions to be answered by the primary medical provider:**

- Can all of the child's symptoms be accounted for by a known medical condition?
- Are there inconsistencies between the medical provider's clinical assessment of the child and the history provided by the parent/caretaker?  
Is there objective evidence (e.g., positive test results) that the child has the signs/symptoms reported by the parent/caretaker?
- Is there evidence that the child's parent/caretaker has provided false information?
- Has treatment for the child been based on objective evidence for an illness or condition or has it been based on parental report of symptoms and demands?
- Has any member of the medical staff witnessed the child's symptoms?
- Have other family members or the child's teachers verified any of the child's symptoms when asked without the parent/caretaker present?  
Has the child failed to respond to standard medical treatments?  
Does the child's parent/caretaker insist on more tests and/or treatments?
- Does the child's parent/caretaker refuse to accept assurance that the child is well?
- Does the child's parent/caretaker resist having the child discharged?

**PART THREE**  
**INVESTIGATION**

Those involved in a Medical Child Abuse investigation should be aware that there is often a lack of consensus among medical providers regarding the diagnosis of Medical Child Abuse. This should *not* be grounds for closing an investigation without further assessment. In many cases, parents who engage in this form of abuse are effective at rallying allies or locating one or more providers who are vulnerable to their deceptions rather than accept the possibility of Medical Child Abuse.

**A. CHILDREN'S PROTECTIVE SERVICES (CPS)**

The CPS investigation begins at assignment of the complaint received. CPS must first determine the child's immediate safety in accordance with CPS policy and procedure. In some cases, CPS may delay notifying the person responsible for the child's health or welfare of the allegations of Medical Child Abuse, if that notification would compromise the safety of the child or the child's siblings or the integrity of the investigation.<sup>2</sup> When necessary, the order in which investigative steps occur can be varied to accommodate the specific needs of the case. Within this framework, investigators can select approaches that match their needs, the safety of the children, and the specifics of individual cases. The steps in the investigation will typically include the following:

1. Consulting with a Child Protection Team.<sup>3</sup>

This consultation should be a team meeting to plan for and determine:

The immediate safety of the child.

- The possible involvement of additional team members and law enforcement.'
- The extent of medical review needed.
- The need for a planned hospitalization.

2. Obtaining medical and other records regarding the child and the family.

- Provide records to medical record reviewer.

3. Completing a medical record review.

4. Completing CPS investigative requirements.

Interview children.

- Interview parents.
- Visit the scene/home.
- Make collateral contacts.
  - o Teacher/school.
  - o Day care providers.
  - o Other medical or mental health providers.

5. Determining CPS case disposition.

- Preponderance of evidence (greater than 50%).

See MCL 722.628(8)

<sup>3</sup>A medically directed multi disciplinary team (involving DHS, law enforcement, a prosecuting attorney, and community professionals) who evaluates suspected child abuse and neglect.

<sup>4</sup> See MCL 722.623 and 722.628

- Type of abuse or neglect.
  - Risk level (low/moderate/high/intensive).
  - Need for legal involvement.
6. Providing for services when abuse or neglect is confirmed.
- Psychological evaluations.
  - Therapeutic services.
  - Substance abuse evaluations/services.
  - Developmental assessments.
  - Other services as determined.

When CPS receives a complaint from a medical professional, an additional medical record review may not be necessary. Using the evidence provided by the medical staff and other evidence obtained throughout the investigation, CPS may have a preponderance of evidence to open a case and service the family.

If the reporting source is not a medical professional, CPS can provide medical records to their own local medical professionals to assist with the dispositional findings.

On rare occasions, CPS may seek out a Comprehensive Medical Assessment by using a medical provider experienced in assessing Medical Child Abuse.

Ongoing consultation between CPS and the providers of the Medical Resource System should continue throughout the investigation.

## **B. COMPREHENSIVE MEDICAL ASSESSMENT:**

### 1. Obtaining Medical Records During the Investigation

CPS may request medical and mental health records without asking parents to sign releases. Michigan law allows the Department of Human Services (OHS), in the course of an investigation into suspected child abuse or neglect, to obtain medical records and mental health records without a court order when such records are pertinent to an investigation of child abuse or neglect.<sup>5</sup> If records are not released, despite this statutory authority, it may be necessary to seek a court order to obtain them. In order for OHS to seek a court order, it must file a child protection petition with the family court.

Information from medical and mental health records is frequently necessary to complete a CPS investigation, to provide information to the court, or to develop a more comprehensive services plan in a CPS case. The Child Protection Law, the Public Health Code (1978 PA 368, MCL.333.2640 & 333.16281) and the Mental Health Code (1974 PA 258, MCL 330.1748a) provide the legal authority and obligation for these providers to share their records with CPS, even without the client's consent. If records requested verbally are not forthcoming from providers, CPS is to make the request in writing, using the Children's Protective Services Request for Medical Information form (DHS-1163-M) or Children's Protective Services Request for Mental Health Information form (DHS-1163-P). If the written request is still denied by the provider, the local office is to send a copy of the denied request to the CPS program office in Lansing. The CPS Program Office will then contact the Department of Community Health for assistance in obtaining the needed records. In an emergency, the local office CPS unit must

<sup>5</sup> See Public Health Code, MCL 333.16281(1) and MCL 330.1748a(1)

seek the assistance of the local prosecuting attorney and Family Division of Circuit Court to obtain records which are needed to protect the child or complete an investigation.<sup>6</sup>

When a court order must be requested to obtain medical records the CPS worker should discuss the case with the OHS attorney and the critical members of the medical team. Ideally the OHS attorney meets with the Child Protection Team and, based on the medical information, provide legal guidance as to whether the evidence is sufficient to file a petition and obtain a court order for the remaining medical records, when needed.

Upon the filing of a petition, the court has the authority to order an evaluation of a child by appropriate medical and psychological experts and the release of medical records to CPS.

## 2. Medical Record Review

A medical provider experienced in assessing Medical Child Abuse should be utilized to complete a comprehensive medical review. The review should include the medical records from all medical providers, hospitals, clinics, and laboratories that provided medical treatment to the child. Insurance companies may be contacted to obtain a complete list of all health care providers and also to obtain a list of medications prescribed.

The following are essential elements of the medical review:

- The medical record reviewer should develop a timeline of the child's medical care.

The reviewer should document whether members of the medical staff have witnessed the signs/symptoms reported by the suspected parent/caretaker.

The goal of the medical review is to determine if a medical condition actually exists or if the reported symptoms are exaggerated, fabricated, or induced. The treating medical provider(s) should be contacted for clarification of symptoms and treatment decisions. It should be noted that having a medical condition does not rule out Medical Child Abuse.

On-going consultation with the Child Protection Team and the Medical Resource System providers should continue throughout the investigation, regardless of who reviewed the medical records.

## 3. Additional Assessment Strategies.

In coordination with the Child Protection Team, the investigation may include the following:

- Planned Hospitalization:** Hospital admission allows medical professionals to closely observe and monitor the child's symptoms in the hospital, to assess interactions between the child and the parent/caretaker, and sometimes to limit or restrict the parent/caretaker's contact with the child. The parent/caretaker should not be made aware of the suspicion of Medical Child Abuse.
- Covert Video Surveillance:** Such surveillance allows the hospital to monitor parent-child interactions without the parent's knowledge and may be helpful in confirming the diagnosis. The absence of video evidence does not rule out Medical Child Abuse.

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<sup>6</sup> PSM 713-6

Covert Video Surveillance is a delicate area legally and should be approached with caution. Hospitals are encouraged to develop their own protocols about surveillance in close consultation with their legal counsel. OHS may seek the guidance of the county prosecutor or Attorney General regarding admissibility in court.

- c. **Temporary Separation:** Either through parental consent or a court order, the child is separated from the suspected offending parent/caretaker while signs/symptoms are monitored. The parent/caretaker should not have contact with the child during this time. A diagnostic separation allows for an objective evaluation of the child's medical status, provides an opportunity to obtain a report of the child's symptoms while away from the suspected parent, and protects the child from possible further abuse. Unless a parent agrees to hospitalization or diagnostic separation, a court order is necessary.

If contact is mandated by the court, it should be limited and supervised closely by the DHS. In carefully controlled circumstances, care of the child by a relative may be appropriate when the family member will limit the suspected offending parent/caretaker's access to the child in accordance with court orders. When this cannot be assured, the child should be placed in non-relative foster care.

## PART FOUR

### POST INVESTIGATIVE ACTIONS

Following a CPS finding of Medical Child Abuse (MCA), OHS workers will continue to ensure coordination among the involved professionals while decisions are made regarding court involvement, provision of services and permanence in accordance with OHS policies. Generally, the OHS worker should ensure the child's current medical providers are aware of and understand the diagnosis of Medical Child Abuse, while making determinations on other issues raised during the case.

As noted on pages 1 and 6, the safety of the child has priority in investigations of Medical Child Abuse and in decisions about providing services in such cases, just as in all other types of abuse and neglect cases. Decisions about safety will also guide OHS in determining the appropriate involvement of the courts in each case.

Possible recommendations in response to decisions about safety and the involvement of a court include but are not limited to:

- A petition for Temporary Wardship (No Request for Removal)  
A petition for Temporary Wardship (Request for Removal of a Parent/Caretaker)
- A petition for Temporary Wardship (Request for Removal of the child)
- A petition for Termination (Request for Removal of the child)

In some circumstances, the OHS will recommend termination of parental rights or some other permanent alternative home for the child at the first dispositional hearing. This will occur when the parental offenses are so egregious and the resources of the perpetrator and extended family so limited that an attempt at treatment is not warranted.

Following determinations about safety and the involvement of a court, OHS should consult with mental health professionals to determine appropriate services for each family member as well as to evaluate whether interventions should be permanent. One possibility is the formulation of a community protection plan that includes people beyond the nuclear family in order to moderate any risks to the child during reunification. For instance, while the child remains a ward of the court, the power to make medical care decisions could remain with someone other than an offending parent. Extended family members, such as a non-offending parent, grandparents, aunts, or uncles, could be engaged to help protect the child from further harm. Therapy could continue for a period of time, as could supervision by the OHS.

Both clinical and forensic psychological evaluations of the perpetrator and victim of MCA will be central to decisions about their treatment. As described in appendix B, these are distinctly different types of evaluations, which provide complementary information from different perspectives. The psychological examination of the perpetrator, a large part of which will be forensic, is not done to confirm a diagnosis of MCA. That diagnosis is a medical judgment which is made by the physician conducting the review of medical records and which serves to place the treatment of the child within a category of child abuse that is defined by Children's Protective Services. The psychological examination of the perpetrator is done after a finding of MCA to evaluate the issues in previous conduct that bear on the perpetrator's need for therapy and supervision. The psychological examination of the victim, which will typically be more clinical in nature, is likewise directed toward determinations of the immediate and ongoing needs of the victim.

## **Psychological Evaluations of Perpetrators of Medical Child Abuse**

The forensic psychological examination of perpetrator's of Medical Child Abuse is done to identify critical treatment issues and appropriate interventions. The psychological evaluation needs to occur early in the case to promote the effective utilization and coordination of services. Forensic methodology is necessary in these cases because of the seriousness of the complaint, because all parties' rights must be protected, and because of the potential for involvement of a court.

The evaluator conducting a psychological evaluation with forensic methodology will meet the following criteria:

- Be appointed by a court, when applicable.
- Have no prior involvement with the family (i.e., as a therapist, past evaluator, friend, etc.).
- Have an objective and neutral stance in the case.

The psychologist will use standard forensic procedures, including the following:

- Clinical observation of psychological and mental status.
- Psychological testing.
- Utilization of multiple sources of data.  
Close scrutiny of collected data.
- Development and testing of hypotheses.
- Review of pertinent documents.
- In-depth interviews.  
Collateral contacts.

The psychological evaluation using forensic methodology has the following uses in cases of Medical Child Abuse.

- To rule out cognitive impairment.
- To assess for mental illness, such as psychosis or affective disorder, as well as any personality disorders.
- To analyze pertinent intrapersonal, interpersonal, and family dynamics.
- To analyze parenting skills.
- To assess the perpetrator's willingness to accept the diagnosis of MCA.

To identify avenues to an barriers to reunification of the family.

- To identify and recommend appropriate interventions and a safety plan.

The report of the evaluator who does the psychological evaluation of the perpetrator of MCA should be comprehensive, with the likelihood that expert testimony may be required from the evaluator. The report needs to follow a standard format for forensic reports and address following issues:

The perpetrator's current cognitive and personality functioning and the presence of any psychopathology or personality disorder.

The perpetrator's perception and awareness of the child's illness and willingness to accept other explanations.

The perpetrator's understanding of the impact of his or her behavior on the child and family and the perpetrator's degree of empathy.

- The intrapersonal, interpersonal, and family issues that might be playing a role.

An analysis of parenting skills.

- An analysis of the potential for reunification, including the perpetrator's amendability to treatment.
- Recommendations for treatment and a plan for safety.

The evaluator performing the psychological evaluation should gather a comprehensive psychosocial history of the perpetrator that includes a summary of the perpetrator's perceptions of the victim's functioning and medical issues. Psychological testing and an examination of mental status will rule out mental retardation and severe mental illness, as well as assess for personality disorders. In addition, an assessment of parenting skills and of the potential for other types of abuse is helpful. However, caution must be used in drawing conclusions from test results, since perpetrators of MCA commonly do not have severe mental illness, and there is no specific profile of perpetrator that can be identified by a test.

### **Psychological Evaluations for Medical Child Abuse Victims**

\ clinical/developmental assessment of children who are victims of MCA may be necessary when a child exhibits cognitive or emotional difficulties. These evaluations should be conducted by an appropriate licensed professional who is familiar with the impact of abuse on child development. When possible, these evaluation should also utilize forensic methodology. Case records related to the abuse should be provided to the evaluator.

**PART FIVE**  
**PERMANENCY**

**Permanency**

Reunification should be a thoughtful process rather than a single act or event, and it should only be considered following successful and well-monitored parental treatment. A decision about reunification should start with the OHS Reunification Assessment, which has three steps:

1. An assessment of compliance with the parenting time plan.
2. An assessment of primary barriers to reunification and risk reduction.
3. A determination about the child's safety.

The issue of reunification is usually raised within one year of placement and following successful treatment. The determination of reunification versus termination of parental rights should be based on successful completion of the treatment plan.

Termination should be strongly considered in cases of Medical Child Abuse when:

- The abuse had a high potential for death.
- Caretakers do not accept the diagnosis of Medical Child Abuse.

Caretakers lack insight into how their pathological health seeking impacted the child

There is continued fabrication and distortion of the child's medical condition.

The extended family does not acknowledge Medical Child Abuse and supports the identified parent's pathological behavior.

There is lack of follow through on recommended services.

## APPENDIX A

### **Medical Resource System (MRS)**

OHS maintains a contract with various medical providers through the Medical Resource System (MRS). This contract provides services such as a 24-hour, 7 day/week statewide hotline for physicians and workers seeking medical consultation on cases involving Child Abuse and Neglect and for physician training. For further information contact the CPS program office.

The telephone number for MRS in southern and eastern Michigan counties is (734) 763-0215. These counties include: Bay, Branch, Calhoun, Genesee, Hillsdale, Huron, Ingham, Jackson, Lapeer, Lenawee, Livingston, Macomb, Monroe, Oakland, St. Clair, Saginaw, Sanilac, Shiawassee, Tuscola, Washtenaw, and Wayne.

For western and northern Michigan counties (counties not listed above), the number is (616) 391-1242.

These numbers may also be found on the OHS public website at:

<http://www.mfia.state.mi.us/olmweb/ex/PSM/713-4.pdf>

## APPENDIX B

### Clinical Evaluation vs. Forensic Evaluation

	Roles	Clinical Psychologist	Forensic Psychologist
1	Who is being served?	Individual patient	Court (or attorney)
2	Purpose	Diagnosis and treatment	Assisting the court in addressing the psycho-legal issue
3	Nature of standard	Medical, psychiatric, and psychological	Psycho-legal issue
4	Areas of competency	Clinical assessment, diagnosis, and treatment	Forensic methodology and assessment
5	Notification of purpose	Less formal notification	Formal, explicit notification, usually written
6	Privilege that governs disclosure	Patient signs release of information	Court (or attorney)
7	Relationship	Accepting, helping, and supportive	Objective and neutral stance
8	Data source	Self-report	Multiple data sources, including collaterals
9	Scrutiny applied	Assumed reliable, much less collateral data	Nothing assumed as reliable, challenges perceptions and uses hypothesis testing
10	Adversarial	Helping and supportive relationship	Frequently adversarial
11	Written report	Reports are shorter and focus on diagnostic and treatment issues	Lengthy and detailed, addressing the psycho-legal issue
12	Court testimony	Not expected	Expected and assumed

Adapted from S. Greenberg and D. Shuman (1997). *Irreconcilable conflict between therapeutic and forensic roles. Professional Psychology: Research and Practice*, 28, 50-57.

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# Appendix

## I

## Cases Involving Digital Evidence

When Team members have located digital evidence or have reason to believe such evidence exists, appropriate investigative measures must be taken to ensure the protection of the evidence and the integrity of the investigation. Below are some of the steps that can be taken to safeguard the material and chain of custody.

- When investigators have probable cause to believe that digital evidence exists, the necessary steps should be taken to obtain a search warrant or consent from someone who has control over the material.
- When conducting searches of locations suspected of containing equipment holding digital evidence, the investigators should have someone with the Team that is familiar in the identification and operation of the equipment. If the Team does not have the resources for digital forensic investigation in their jurisdiction, the Team is encouraged to contact their nearest ICAC (Internet Crimes Against Children) Task Force.
- Recovered digital evidence should be forensically examined by a trained and certified professional. If the Team does not have this resource in their jurisdiction, the Team should contact their nearest ICAC Task Force.
- If the Team has digital evidence of the abuse/neglect prior to the Forensic Interview, the Team should refer to Quick Guide #6: Guidelines for the Use of Physical Evidence, in the *Forensic Interviewing Protocol*, prior to the Forensic Interview.
- Copies of any sexually abusive material should be submitted to the Child Victim Identification Program (CVIP) at the National Center for Missing and Exploited Children (NCMEC). Submission guidelines can be found on the NCMEC website, [www.ncmec.org](http://www.ncmec.org).
- All handling of sexually abusive material MUST follow the protocol set forth in the Adam Walsh Child Protection and Safety Act (42 U.S.C. §16911 *et seq*).

# Appendix

J

**MCLS § 722.628 (2016)**

**§ 722.628. Referring report or commencing investigation; informing parent or legal guardian of investigation; duties of department; assistance of and cooperation with law enforcement officials; procedures; procedures by prosecuting attorney; cooperation of school or other institution; information as to disposition of report; exception to reporting requirement; surrender of newborn; training of employees in rights of children and families; determination of open friend of the court case.**

Sec. 8. **(1)** Within 24 hours after receiving a report made under this act, the department shall refer the report to the prosecuting attorney and the local law enforcement agency if the report meets the requirements of subsection (3)(a), (b), or (c) or section 3(6) or (9) or shall commence an investigation of the child suspected of being abused or neglected. Within 24 hours after receiving a report whether from the reporting person or from the department under subsection (3)(a), (b), or (c) or section 3(6) or (9), the local law enforcement agency shall refer the report to the department if the report meets the requirements of section 3(7) or shall commence an investigation of the child suspected of being abused or neglected or exposed to or who has had contact with methamphetamine production. If the child suspected of being abused or exposed to or who has had contact with methamphetamine production is not in the physical custody of the parent or legal guardian and informing the parent or legal guardian would not endanger the child's health or welfare, the agency or the department shall inform the child's parent or legal guardian of the investigation as soon as the agency or the department discovers the identity of the child's parent or legal guardian.

**(2)** In the course of its investigation, the department shall determine if the child is abused or neglected. The department shall cooperate with law enforcement officials, courts of competent jurisdiction, and appropriate state agencies providing human services in relation to preventing, identifying, and treating child abuse and neglect; shall provide, enlist, and coordinate the necessary services, directly or through the purchase of services from other agencies and professions; and shall take necessary action to prevent further abuses, to safeguard and enhance the child's welfare, and to preserve family life where possible. In the course of an investigation, at the time that a department investigator contacts an individual about whom a report has been made under this act or contacts an individual responsible for the health or welfare of a child about whom a report has been made under this act, the department investigator shall advise that individual of the department investigator's name, whom the department investigator represents, and the specific complaints or allegations made against the individual. The department shall ensure that its policies, procedures, and administrative rules ensure compliance with the provisions of this act.

**(3)** In conducting its investigation, the department shall seek the assistance of and cooperate with law enforcement officials within 24 hours after becoming aware that 1 or more of the following conditions exist:

**(a)** Abuse or neglect is the suspected cause of a child's death.

**(b)** The child is the victim of suspected sexual abuse or sexual exploitation.

**(c)** Abuse or neglect resulting in severe physical injury to the child. For purposes of this subdivision and section 17, "severe physical injury" means an injury to the child that requires medical treatment or hospitalization and that seriously impairs the child's health or physical well-being.

(d) Law enforcement intervention is necessary for the protection of the child, a department employee, or another person involved in the investigation.

(e) The alleged perpetrator of the child's injury is not a person responsible for the child's health or welfare.

(f) The child has been exposed to or had contact with methamphetamine production.

(4) Law enforcement officials shall cooperate with the department in conducting investigations under subsections (1) and (3) and shall comply with sections 5 and 7. The department and law enforcement officials shall conduct investigations in compliance with the protocols adopted and implemented as required by subsection (6).

(5) Involvement of law enforcement officials under this section does not relieve or prevent the department from proceeding with its investigation or treatment if there is reasonable cause to suspect that the child abuse or neglect was committed by a person responsible for the child's health or welfare.

(6) In each county, the prosecuting attorney and the department shall develop and establish procedures for involving law enforcement officials as provided in this section. In each county, the prosecuting attorney and the department shall adopt and implement standard child abuse and neglect investigation and interview protocols using as a model the protocols developed by the governor's task force on children's justice as published in FIA Publication 794 (revised 8-98) and FIA Publication 779 (8-98), or an updated version of those publications.

(7) If there is reasonable cause to suspect that a child in the care of or under the control of a public or private agency, institution, or facility is an abused or neglected child, the agency, institution, or facility shall be investigated by an agency administratively independent of the agency, institution, or facility being investigated. If the investigation produces evidence of a violation of section 145c or sections 520b to 520g of the Michigan penal code, 1931 PA 328, MCL 750.145c and 750.520b to 750.520g, the investigating agency shall transmit a copy of the results of the investigation to the prosecuting attorney of the county in which the agency, institution, or facility is located.

(8) A school or other institution shall cooperate with the department during an investigation of a report of child abuse or neglect. Cooperation includes allowing access to the child without parental consent if access is determined by the department to be necessary to complete the investigation or to prevent abuse or neglect of the child. The department shall notify the person responsible for the child's health or welfare about the department's contact with the child at the time or as soon afterward as the person can be reached. The department may delay the notice if the notice would compromise the safety of the child or child's siblings or the integrity of the investigation, but only for the time 1 of those conditions exists.

(9) If the department has contact with a child in a school, all of the following apply:

(a) Before contact with the child, the department investigator shall review with the designated school staff person the department's responsibilities under this act and the investigation procedure.

(b) After contact with the child, the department investigator shall meet with the designated school staff person and the child about the response the department will take as a result of contact with the child. The department may also meet with the designated school staff person without the

child present and share additional information the investigator determines may be shared subject to the confidentiality provisions of this act.

(c) Lack of cooperation by the school does not relieve or prevent the department from proceeding with its responsibilities under this act.

(10) A child shall not be subjected to a search at a school that requires the child to remove his or her clothing to expose his buttocks or genitalia or her breasts, buttocks, or genitalia unless the department has obtained an order from a court of competent jurisdiction permitting such a search. If the access occurs within a hospital, the investigation shall be conducted so as not to interfere with the medical treatment of the child or other patients.

(11) The department shall enter each report made under this act that is the subject of a field investigation into the CPSI system. The department shall maintain a report entered on the CPSI system as required by this subsection until the child about whom the investigation is made is 18 years old or until 10 years after the investigation is commenced, whichever is later, or, if the case is classified as a central registry case, until the department receives reliable information that the perpetrator of the abuse or neglect is dead. Unless made public as specified information released under section 7d, a report that is maintained on the CPSI system is confidential and is not subject to the disclosure requirements of the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246.

(12) After completing a field investigation and based on its results, the department shall determine in which single category, prescribed by section 8d, to classify the allegation of child abuse or neglect.

(13) Except as provided in subsection (14), upon completion of the investigation by the local law enforcement agency or the department, the law enforcement agency or department may inform the person who made the report as to the disposition of the report.

(14) If the person who made the report is mandated to report under section 3, upon completion of the investigation by the department, the department shall inform the person in writing as to the disposition of the case and shall include in the information at least all of the following:

(a) What determination the department made under subsection (12) and the rationale for that decision.

(b) Whether legal action was commenced and, if so, the nature of that action.

(c) Notification that the information being conveyed is confidential.

(15) Information sent under subsection (14) shall not include personally identifying information for a person named in a report or record made under this act.

(16) Unless section 5 of chapter XII of the probate code of 1939, 1939 PA 288, MCL 712.5, requires a physician to report to the department, the surrender of a newborn in compliance with chapter XII of the probate code of 1939, 1939 PA 288, MCL 712.1 to 712.20, is not reasonable cause to suspect child abuse or neglect and is not subject to the section 3 reporting requirement. This subsection does not apply to circumstances that arise on or after the date that chapter XII of the probate code of 1939, 1939 PA 288, MCL 712.1 to 712.20, is repealed. This subsection applies to a newborn whose birth is described in the born alive infant protection act, 2002 PA 687, MCL 333.1071 to 333.1073, and who is considered to be a newborn surrendered under the safe delivery of new-

boms law as provided in section 3 of chapter XII of the probate code of 1939, 1939 PA 288, MCL 712.3.

(17) All depaiiment employees involved in investigating child abuse or child neglect cases shall be trained in the legal duties to protect the state and federal constitutional and statutory rights of children and families from the initial contact of an investigation through the time services are provided.

(18) The department shall determine whether there is an open friend of the court case regarding a child who is suspected of being abused or neglected if a child protective services investigation of child abuse and neglect allegations result in any of the following dispositions:

(a) A finding that a preponderance of evidence indicates that there has been child abuse and neglect.

(b) Emergency removal of the child for child abuse and neglect before the investigation is completed.

(c) The family court takes jurisdiction on a petition and a child is maintained in his or her own home under the supervision of the department.

(d) If 1 or more children residing in the home are removed and 1 or more children remain in the home.

(e) Any other circumstances that the department determines are applicable and related to child safety.

(19) If the department determines that there is an open friend of the court case and the provisions of subsection (18) apply, the department shall notify the office of the friend of the court in the county in which the friend of the court case is open that there is an investigation being conducted under this act regarding that child and shall also report to the local friend of the court office when there is a change in that child's placement.

(20) Child protective services may report to the local friend of the court office any situation in which a parent, more than 3 times within 1 year or on 5 cumulative reports over several years, made unfounded reports to child protective services regarding alleged child abuse or neglect of his or her child.

(21) If the department determines that there is an open friend of the court case, the department shall provide noncustodial parents of a child who is suspected of being abused or neglected with the form developed by the department that has information on how to change a custody or parenting time court order.