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COMPLAINTS AND REPORTS

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COMPLAINTS AND REPORTS

3.1 Legal basis

The Code of Virginia [§ 63.2-1503 B and C](#) mandates that local departments of social services (LDSS) maintain the capability to receive reports and complaints alleging abuse or neglect on a 24-hour, 7-days-a-week basis.

3.2 24-Hour hotline and receiving complaints and reports

The Virginia Administrative Code (VAC) provides that a person may make a report or complaint by telephoning the toll-free Child Abuse and Neglect Hotline of the Virginia Department of Social Services (VDSS) or by contacting a LDSS.

[\(22 VAC 40-705-40 H\)](#). To make a complaint or report of child abuse and/or neglect, a person may telephone the department's toll-free child abuse and neglect hotline or contact a local department of jurisdiction pursuant to [§ 63.2-1510](#) of the Code of Virginia.

The statewide toll-free CPS Hotline (**1-800-552-7096**) shall be available 24 hours a day, seven days a week. After receiving a complaint or report of child abuse or neglect, the CPS State Hotline worker will refer the complaint or report to the LDSS immediately or no later than the next working day.

3.3 Persons who may make a complaint or report

The Code of Virginia [§§ 63.2-1509](#) and [63.2-1510](#) provide the authority for persons to report suspected abuse or neglect and allows any person who suspects that a child is abused or neglected to make a complaint or report. The Code of Virginia [§ 63.2-1509](#) further identifies certain persons who are mandated to report suspected abuse or neglect. The VAC defines the terms "complaint" and "report."

[\(22 VAC 40-705-10\)](#). "Complaint" means any information or allegation of child abuse and/or neglect made orally or in writing pursuant to [§ 63.2-100](#) of the Code of Virginia.

[\(22 VAC 40-705-10\)](#). "Report" means either a complaint as defined in this section or an official document on which information is given concerning abuse and neglect and which is

required to be made by persons designated herein and by local departments in those situations in which a complaint from the general public reveals suspected child abuse and/or neglect pursuant to subdivision 5 of the definition of abused or neglected child in § [63.2-100](#) of the Code of Virginia.

3.3.1 Mandated reporters

The VAC defines mandated reporters and their reporting responsibilities:

([22 VAC 40-705-10](#)). "Mandated reporters" means those persons who are required to report suspicions of child abuse and/or neglect pursuant to § [63.2-1509](#) of the Code of Virginia.

([22 VAC 40-705-40 A](#)). Persons who are mandated to report are those individuals defined in § [63.2-1509](#) of the Code of Virginia.

1. Mandated reporters shall report immediately any suspected abuse or neglect that they learn of in their professional capacity. No person shall be required to make a report pursuant to § [63.2-1509](#) of the Code of Virginia if the person has actual knowledge that the same matter has already been reported to the local department or the department's toll-free child abuse and neglect hotline.

2. Pursuant to § [63.2-1509](#) of the Code of Virginia, if information is received by a teacher, staff member, resident, intern, or nurse in the course of his professional services in a hospital, school, or similar institution, such person may, in place of said report, immediately notify the person in charge of the institution or department, or his designee, who shall then make such report forthwith. If the initial report of suspected abuse or neglect is made to the person in charge of the institution or department, or his designee, such person shall (i) notify the teacher, staff member, resident, intern, or nurse who made the initial report when the report of suspected child abuse or neglect is made to the local department or to the department's toll-free child abuse and neglect hotline; (ii) provide the name of the individual receiving the report; and (iii) forward any communication resulting from the report, including any information about any actions taken regarding the report, to the person who made the initial report.

3. Mandated reporters shall disclose all information which is the basis for the suspicion of child abuse or neglect and shall make available, upon request, to the local department any records and reports which document the basis for the complaint and/or report.

4. A mandated reporter's failure to report as soon as possible, but no longer than 24 hours after having reason to suspect a reportable offense of child abuse or neglect shall result in

a fine. In cases evidencing acts of rape, sodomy, or object sexual penetration as defined in Article 7 ([§ 18.2-61](#) et seq.) of Chapter 4 of Title 18.2 of the Code of Virginia, a person who knowingly and intentionally fails to make the report required pursuant to [§ 63.2-1509](#) of the Code of Virginia shall be guilty of a Class 1 misdemeanor.

3.3.1.1 Who are mandated reporters?

The Code of Virginia identifies those persons who are mandated reporters. These persons shall report suspected abuse or neglect that they suspect when in their professional or official capacity.

Mandated reporter training and other resources for mandated reporters are available from VDSS on the [VDSS public website](#).

([§ 63.2-1509 A](#) of the Code of Virginia). The following persons who, in their professional or official capacity, have reason to suspect that a child is an abused or neglected child, shall report the matter immediately, except as hereinafter provided, to the local department of the county or city wherein the child resides or wherein the abuse or neglect is believed to have occurred or to the Department's toll free child abuse and neglect hotline:

1. Any person licensed to practice medicine or any of the healing arts;
2. Any hospital resident or intern, and any person employed in the nursing profession;
3. Any person employed as a social worker or family services specialist;
4. Any probation officer;
5. Any teacher or other person employed in a public or private school, kindergarten or nursery school;
6. Any person providing full-time or part-time child care for pay on a regularly planned basis;
7. Any mental health professional;
8. Any law-enforcement officer or animal control officer;
9. Any mediator eligible to receive court referrals pursuant to [§ 8.01-576.8](#);
10. Any professional staff person, not previously enumerated, employed by a private or state-operated hospital, institution or facility to which children have been committed or where children have been placed for care and treatment;

11. Any person, 18 years of age or older, associated with or employed by any public or private organization responsible for the care, custody or control of children; and
12. Any person who is designated a court-appointed special advocate pursuant to Article 5 (§ [9.1-151](#) et seq.) of Chapter 1 of Title 9.1.
13. Any person, 18 years of age or older, who has received training approved by the Department of Social Services for the purposes of recognizing and reporting child abuse and neglect.
14. Any person employed by a local department as defined in § [63.2-100](#) who determines eligibility for public assistance.
15. Any emergency medical services personnel certified by the Board of Health pursuant to § [32.1-111.5](#), unless such personnel immediately reports the matter directly to the attending physician at the hospital to which the child is transported, who shall make such report forthwith;
16. Any athletic coach, director or other person 18 years of age or older employed by or volunteering with a private sports organization or team;
17. Administrators or employees, 18 years of age or older, of public or private day camps, youth centers and youth recreation programs; and
18. Any person employed by a public or private institution of higher education other than an attorney who is employed by a public or private institution of higher education as it relates to information gained in the course of providing legal representation to a client.

This subsection shall not apply to any regular minister, priest, rabbi, imam, or duly accredited practitioner of any religious organization or denomination usually referred to as a church as it relates to (i) information required by the doctrine of the religious organization or denomination to be kept in a confidential manner or (ii) information that would be subject to [§ 8.01-400](#) or [19.2-271.3](#) if offered as evidence in court.

Foster and adoptive parents and respite providers are considered mandated reporters due to their association with a public organization that is responsible for the care, custody and control of children as referenced in [§ 63.2-1509 A11](#).

3.3.1.2 Certain mandated reporters may make a report to the person in charge or their designee

([22 VAC 40-705-40 A](#)) Pursuant to [§ 63.2-1509 A](#) of the Code of Virginia, if the information is received by a teacher, staff member, resident, intern or nurse in the course of professional services in a hospital, school or similar institution, such person may, in place of said report, immediately notify the person in charge of the institution or department, or his designee, who shall make such report forthwith. If the initial report of suspected abuse or neglect is made to the person in charge of the institution or department, or his designee, pursuant to this subsection, such person shall notify the teacher, staff member, resident, intern or nurse who made the initial report when the report of suspected child abuse or neglect is made to the local department or to the Department's toll-free child abuse and neglect hotline, and of the name of the individual receiving the report, and shall forward any communication resulting from the report, including any information about any actions taken regarding the report, to the person who made the initial report.

The VAC allows certain mandated reporters to make a report to the person in charge or a designee. If the report is made to another person, that person must report back to the original mandated reporter 1) when the report was made; 2) who received the report; and 3) relay any further information back to the original reporter, including any final notifications.

3.3.1.3 Mandated reporter shall disclose all relevant information even if not the complainant

The Code of Virginia [§ 63.2-1509 A](#) specifies when a mandated reporter makes a report of suspected abuse or neglect; the reporter shall disclose all the information that is the basis of the report to the LDSS. This includes any records or reports documenting the basis of the allegation.

All mandated reporters, even if they are not the complainant, shall cooperate with the LDSS and shall make related information, records and reports about the child who is the subject of the report available to the LDSS for the purpose of validating a CPS referral and for completing a CPS response unless such disclosure violates the federal [Family Educational Rights and Privacy Act \(20 U.S.C. § 1232\(g\)\)](#).

Provision of such information, records, and reports by a health care provider shall not be prohibited by the Code of Virginia [§ 8.01-399](#).

Criminal investigative reports received from law-enforcement agencies shall not be further disseminated by the investigating agency nor shall they be subject to public disclosure.

Although obtaining parental consent to obtain information is always preferable, consent is not required for the release of information for the purpose of validating a referral or completing an investigation or family assessment.

3.3.1.4 Failure by mandated reporter to report abuse or neglect

According to the Code of Virginia [§ 63.2-1509 D](#), a person required to report who fails to do so as soon as possible, but **not longer than 24 hours** after having a reason to suspect a reportable offense of child abuse or neglect shall be fined not more than \$500 for the first failure and for any subsequent failures not less than \$1000. If the LDSS becomes aware of an incident involving a mandated reporter who failed to report pursuant to the Code of Virginia [§ 63.2-1509 A and B](#), the LDSS must report the incident to the local Commonwealth's Attorney.

If a person knowingly and intentionally fails to report cases involving rape, sodomy, or object sexual penetration, they shall be guilty of a Class 1 misdemeanor.

If a person has actual knowledge that the same matter has already been reported they are not required to contact the LDSS or the state hotline.

3.3.1.5 Physicians reporting venereal disease

Physicians who diagnose venereal disease in a child 12 years of age or under shall make a CPS report to the LDSS. Physicians need not report cases of venereal disease when they reasonably believe that the infection was caused congenitally or by means other than sexual abuse. The Code of Virginia [§ 32.1-36 A](#) provides that practicing physicians and laboratory directors shall report patients' diseases as prescribed by the State Board of Medicine. See the Code of Virginia [§ 32.1-36 A and B](#).

3.3.2 Other persons may make a report of alleged child abuse or neglect

[\(22 VAC 40-705-40 B\)](#). Persons who may report child abuse and/or neglect include any individual who suspects that a child is being abused and/or neglected pursuant to [§ 63.2-1510](#) of the Code of Virginia.

Any individual suspecting that a child is abused or neglected may make a complaint to the VDSS or to an LDSS. The person can make the complaint to the LDSS in the county or city where the alleged victim child resides or where the alleged abuse or neglect occurred. The person may also make the complaint by calling the CPS State Hotline **(1-800-552-7096)**.

3.3.3 Complaints and reports may be made anonymously

([22 VAC 40-705-40 C](#)). Complaints and reports of child abuse and/or neglect may be made anonymously. An anonymous complaint, standing alone, shall not meet the preponderance of evidence standard necessary to support a founded determination.

Reports or complaints alleging abuse or neglect may be made anonymously and the LDSS cannot require the individual to reveal his identity as a condition of accepting the report. All reports shall be documented in the automated data system and evaluated for validity and a CPS response regardless of whether or not the caller is identified.

3.3.4 Issues related to reporting

3.3.4.1 Immunity from liability for persons making a report

([22 VAC 40-705-40 D](#)). Any person making a complaint and/or report of child abuse and/or neglect shall be immune from any civil or criminal liability in connection therewith, unless the court decides that such person acted in bad faith or with malicious intent pursuant to [§ 63.2-1512](#) of the Code of Virginia.

The following persons are immune from any civil or criminal liability unless it is proven that such person acts with malicious intent:

- Any person making a report or complaint of child abuse or neglect.
- Any person who participates in a judicial proceeding resulting from either making a report or taking a child into immediate custody.

3.3.4.2 Protecting the identity of the reporter or complainant

([22 VAC 40-705-40 E](#)). When the identity of the reporter is known to the Department or local department, these agencies shall make every effort to protect the reporter's identity.

When the complainant is known to the LDSS, every effort shall be made to protect that person's anonymity. However, the complainant shall also be informed that his anonymity cannot be assured if the case is brought into court.

3.4 Actions upon receipt of complaint or report

3.4.1 Statutory authorities and responsibilities

The Code of Virginia [§ 63.2-1503](#) requires an LDSS to determine the validity of all reports and to decide whether to conduct a family assessment, if designated to do

so, or an investigation, if the report or complaint alleging child abuse or neglect is valid.

3.4.2 Document receipt of complaint or report in automated data system

Pursuant to the Code of Virginia, § [63.2-1505 B 2](#), when a complaint or report alleging abuse or neglect is received, the LDSS shall enter the report into the automated data system.

3.4.3 The LDSS shall record all complaints and reports in writing

[\(22 VAC 40-705-50 A\)](#). All complaints and reports of suspected child abuse and/or neglect shall be recorded in the child abuse and neglect information system and either screened out or determined valid within 5 days of receipt. A record of all reports and complaints made to a local department or to the Department, regardless of whether the report or complaint was found to be a valid complaint of abuse and/or neglect, shall be retained for one year from the date of the complaint.

All complaints or reports made to the VDSS or an LDSS shall be documented in the automated data system. A person may make the initial complaint or report alleging abuse or neglect orally or in writing. The LDSS must document the report or complaint in the automated data system within **three working days**, regardless of whether the complaint or report is determined to be valid or invalid. Timeliness of the initial response is calculated from the date and time the referral was received, not validated or assigned.

3.4.3.1 New allegations in an existing family assessment or investigation

When a report has been accepted as valid and the investigation or family assessment response is initiated and subsequent allegations are made, the type of allegation and the time elapsed since the initial report will determine whether the new allegation is treated as a new report or assessed within the context of the existing response. If the allegations do not provide any new or different information, they may be added into the initial investigation or family assessment. If the additional allegations address new types of abuse/neglect and **five (5) or more days** have elapsed since the first report, the additional allegations should be taken as a new report and screened using the CPS Intake Tool.

3.5 Determine validity of complaint or report

When an LDSS receives a report or complaint of abuse or neglect, the LDSS must determine whether the complaint or report is valid **within five (5) days** of receiving the complaint. Criteria are established for determining whether a complaint or report is valid.

Each criterion must be satisfied before a complaint or report can be valid. Only valid reports or complaints of abuse or neglect shall receive a family assessment or an investigation. It is important to make the validity decision as soon as possible after the report has been received so that the urgency of the response can be accurately determined. Response time is calculated from the date and time the referral was received, not validated or assigned.

When determining validity, the LDSS must use the CPS Intake Tool for all reports of child abuse and neglect including new reports during open cases. The CPS Intake Tool must be completed in the automated data system as soon as possible, but **no later than three working days**, upon receipt of the report by the LDSS. It is critical that the intake worker using the CPS Intake Tool review the definitions available on the tool when making selections on the checklist. Selections made on the CPS Intake Tool must relate to supporting narrative in the automated data system. The CPS Intake Tool with definitions is located on the forms page on the [DSS public website](#) or in [Appendix D](#) of this section.

3.5.1 Definition of valid complaint or report

The Code of Virginia [§ 63.2-1508](#) and the VAC define a valid complaint.

[\(22 VAC 40-705-50 B\)](#). In all valid complaints or reports of child abuse and/or neglect the local department of social services shall determine whether to conduct an investigation or a family assessment. A valid complaint or report is one in which:

1. The alleged victim child or children are under the age of 18 at the time of the complaint and/or report;
2. The alleged abuser is the alleged victim child's parent or other caretaker;
3. The local department receiving the complaint or report is a local department of jurisdiction; and
4. The circumstances described allege suspected child abuse and/or neglect as defined in [§ 63.2-100](#) of the Code of Virginia.

3.5.2 Determine whether the complaint or report is valid

There are four criteria that must be addressed when determining whether the complaint or report is valid. Each question must be satisfied in order to have a valid report. The four elements are:

3.5.2.1 Question 1: Is the alleged victim child under eighteen years of age?

([22 VAC 40-705-50 B 1](#)). The alleged victim child or children are under the age of 18 at the time of the complaint and/or report.

The LDSS can only respond with a family assessment or an investigation to valid complaints or reports involving children less than 18 years of age at the time of the report or complaint. If the alleged victim is over 18 years of age, the LDSS should refer that person to the local attorney for the Commonwealth, Adult Protective Services, or other appropriate services provided in the locality.

3.5.2.1.1 Emancipated minor

If the alleged victim child is under 18 years of age and has been legally emancipated, then the LDSS has the discretion of not completing a family assessment or investigating the complaint.

The LDSS may determine a report of abuse or neglect as invalid if a court has emancipated the alleged victim of the abuse or neglect pursuant to the Code of Virginia §§ [16.1-331](#) and [16.1-332](#).

The Code of Virginia §§ [16.1-331](#), [16.1-332](#), and [16.1-333](#) require petitioning the juvenile court and the court conducting a hearing before making a finding of emancipation. The LDSS must confirm that the child has been legally emancipated before invalidating the complaint or report.

3.5.2.1.2 Alleged victim child is married

There is no specific Code of Virginia or VAC provision prohibiting the validation of a complaint involving an alleged victim child who is married. When an LDSS receives a complaint involving a married child, the first issue the LDSS may address is whether the alleged victim child is emancipated. If the alleged victim child is married and emancipated, then the LDSS should invalidate the complaint or report.

A husband or wife of the alleged victim cannot be considered a caretaker.

3.5.2.2 Question 2: Is the alleged abuser or neglecter a caretaker?

([22 VAC 40-705-50 B 2](#)). The alleged abuser is the alleged victim child's parent or other caretaker.

The second element of a valid complaint is the alleged abuser or neglecter must be a caretaker. The VAC defines caretaker in [22VAC 40-705-10](#).

A caretaker is an individual who is responsible or assumes responsibility for providing care and supervision for the child. There are three (3) general categories of caretakers:

- A parent or other person legally responsible for the child's care includes:
 - Birth parent.
 - Adoptive parent.
 - Stepparent.
 - Legal guardian.
 - Foster parent.
- An individual who by law, social custom, expressed or implied acquiescence, collective consensus, agreement or any other legally recognizable basis has an obligation to look after the child left in their care may include but is not limited to:
 - Relative.
 - Babysitter.
 - Paramour of the parent.
 - Cohabitants.

For all such individuals in this category, the LDSS must be able to document how the care and control of the child was expressly delegated or implied to the individual, as well as take into consideration the factors listed in 3.5.2.2.1. For example, a person who merely resides in the same home as the child but was never delegated any authority over the child and in fact did not exercise any control over the child is not a caretaker. ([Moore v. Brown](#), 2014 Va. App. LEXIS 181.)

- Individuals responsible by virtue of their positions of conferred authority includes but is not limited to:
 - Teacher or other school personnel.
 - Institutional staff.
 - Child care personnel.
 - Scout troop leaders.

3.5.2.2.1 Caretaker considerations

When determining whether a person is responsible for the care of a child, the LDSS should consider the amount of authority for the care, control and discipline of the child delegated to the person acting as a caretaker. The LDSS should gather sufficient evidence to demonstrate that the alleged abuser/neglector is a caretaker and document such evidence in the automated data system. The LDSS should consider these issues when determining whether a person is a caretaker.

- What is the person's relationship with the child?
- What is that person's role or function toward the child?
- Was the person in a caretaking role at the time of the alleged abusive or neglectful incident?
- Was the primary responsibility of the person toward the child one of supervision and providing care, or was the person providing a professional or expert service?
- How do the child and the child's usual caretaker view this relationship and role?
- How does the community view this relationship and role?
- Have the parents or other person specifically delegated formally or informally the caretaking role for this person?
- What were the expectations of the parent, alleged abuser/neglector and child?

3.5.2.2.2 Caretakers less than 18 years of age

The LDSS should consider these additional issues when determining if a minor is a caretaker:

- Was it appropriate for the minor to have been put in a caretaking role?
- Was the alleged abuse or neglect by the minor indicative of their own abuse? (i.e., sexual knowledge or behavior that is age inappropriate)
- What is the age difference between the alleged abuser and the victim; was this peer interaction?

If it is determined that a minor may have abused or neglected a child but the minor should not have been placed in a caretaker role, the LDSS may determine the minor to be the victim child of the caretaker who put them in that role. If it is determined that a minor may have sexually abused the child and the minor is not determined to be a caretaker, refer to section 3.5.4.2 for additional guidance on reporting non-caretaker sexual abuse.

3.5.2.3 Question 3: Is abuse or neglect alleged to have occurred?

([22 VAC 40-705-50 B 4](#)). The circumstances described allege suspected child abuse and/or neglect as defined in § [63.2-100](#) of the Code of Virginia.

The complaint or report must describe a type of abuse or neglect as defined in [22 VAC 40-705-30](#) and/or section 2: Definitions of Abuse and Neglect of this guidance manual.

3.5.2.3.1 General factors to consider when determining if abuse or neglect definition has been met

The CPS worker must consider the following questions to determine if the definition of physical abuse has been met.

- What was the action or inaction of the caretaker?
- Did the child sustain an injury or is there evidence establishing that the child was threatened with sustaining an injury?
- Does the evidence establish a nexus, or causal relationship between the action or inaction of the caretaker and the physical injury or threatened physical injury to the child?
- Was the injury, or threat of injury, caused by non-accidental means?

3.5.2.3.2 Establish injury or threat of an injury

The report or complaint must allege a threat of injury or actual injury to the child to satisfy the definition of abuse or neglect. The Code of Virginia and the VAC do not require that the child sustain an actual injury.

3.5.2.3.3 Establish nexus between caretaker's actions or inaction and the injury or threatened injury to the child

The complaint or report must allege a link between the actions or inaction of the caretaker, regardless of the caretaker's intent, and the injury to the child or the threat of injury to the child.

3.5.2.3.4 “Other than accidental means”

The injury or threat of injury to the child must have occurred as a result of “other than accidental means.” The caretaker’s actions must be carefully considered when determining whether the injury or threat of injury sustained by the child was caused accidentally.

For example, the complaint alleged that the caretaker caused bruises and abrasions on the child’s ankles and wrists. The caretaker asserted that he did not intend to cause the injuries to the child; he intended to restrain the five-year-old boy with a rope. However, the evidence shows that the caretaker tied the child’s legs at the ankles and tied the wrists to a chair, and when the child jerked in several different directions for over 20 minutes to try to get loose, injuries occurred to these parts of the body. The caretaker did not accidentally tie the child and leave him for 20 minutes. Although the caretaker did not intend to cause the injuries to the child, the caretaker did intend to tie the child, and could reasonably expect this child would try to get loose. The caretaker’s act of restraining this child with a rope was intended and could have caused more serious harm. The result of the caretaker’s actions was not unforeseen or unexpected. Therefore, the injury was not accidental.

In the alternative, a black eye to the child’s face while playing catch with the caretaker would be considered accidental. The fact that the ball bounced off the child’s mitt and struck the child’s eye was not intended. In the first example, the caretaker intended to discipline his child by restraining with a rope for 20 minutes. The intended act of restraining the child caused the injury to the child. In the second example, the caretaker did not intend for the ball to bounce off the child’s mitt and hit the child’s face. The action causing the black eye was accidental.

3.5.2.3.5 Determine if medical neglect definition has been met

It is the parent’s responsibility to determine and obtain appropriate medical, mental and dental care for a child. What constitutes adequate medical treatment for a child cannot be determined in a vacuum free of external influences, but rather, each case must be decided on its own particular facts. The focus of the CPS response are whether the caretaker failed to provide medical treatment and whether the child was harmed or placed at risk of harm as a result of the failure. Cultural and religious child-rearing practices and beliefs that differ from general community standards should not be considered a basis for medical neglect, unless the practices present a specific danger to the physical or emotional safety of the child.

- **Treatment or care must be necessary.** The statutory definition of medical neglect requires that the parent neglects or refuses to

provide necessary care for the child's health. Therefore, the LDSS must establish that the caretaker's failure to follow through with a complete regimen of medical, mental or dental care for a child was necessary for the child's health. The result of the caretaker's failure to provide necessary care could be illness or developmental delays. The challenging issue is determining when medical care is necessary for the child's health. Obviously, life-saving medical treatment is necessary and falls within the definition. However, when parents or caretakers refuse medical care that is important to their child's well-being but is not essential to life, the issue becomes more complicated in determining whether the medical care is necessary.

- **Assess degree of harm (real or threatened) to the child.** When assessing whether the medical, mental or dental treatment is necessary for the child's health, the LDSS should consider the degree of harm the child suffered as a result of the lack of care. If the child has yet to suffer harm, then the LDSS should assess the likelihood that the child will suffer harm. The greater the harm, the more necessary the treatment.
- In addition to harm, the LDSS should consider the type of medical, mental or dental condition involved and whether the condition is stable or progressive. Whether the condition is stable or progressive may be an issue in determining the severity of the condition and the necessity of treatment. If the condition of the child is stable, then the LDSS may consider deferring to the caretaker's authority. If the condition is progressive and left untreated, then the LDSS may give lesser deference to the caretaker's authority.
- **Parent refuses treatment for life-threatening condition.** Pursuant to the Code of Virginia [§ 63.2-100](#), a parent's decision to refuse a particular medical treatment for a child with a life-threatening condition shall not be deemed a refusal to provide necessary care when all the following conditions are met:
 - The decision is made jointly by the child and the parents or other person legally responsible for the child.
 - The child has reached 14 years of age and sufficiently mature to have an informed opinion on the subject of his medical treatment.
 - The child and the parents or other person legally responsible for the child have considered alternative treatment options.

- The child and the parents or other person legally responsible for the child believe in good faith that such decision is in the child's best interest.

The VAC provides definitions of some of the terms in the Code of Virginia.

([22 VAC 40-705-10](#)). “Particular medical treatment” means a process or procedure that is recommended by conventional medical providers and accepted by the conventional medical community.

“Sufficiently mature” is determined on a case-by-case basis and means that a child has no impairment of his cognitive ability and is of a maturity level capable of having intelligent views on the subject of his health condition and medical care.

“Informed opinion” means that the child has been informed and understands the benefits and risks, to the extent known, of the treatment recommended by conventional medical providers for his condition and the alternative treatment being considered as well as the basis of efficacy for each, or lack thereof.

“Alternative treatment options” means treatments used to prevent or treat illnesses or promote health and well-being outside the realm of modern conventional medicine.

“Life-threatening condition” means a condition that if left untreated more likely than not will result in death and for which the recommended medical treatments carry a probable chance of impairing the health of the individual or a risk of terminating the life of the individual.

- **Assess caretaker's rationale.** The most singular underlying issue in determining whether a child is being deprived of adequate medical care, and therefore, a medically neglected child, is whether the parents have provided an acceptable course of medical treatment for their child in light of all the surrounding circumstances. The LDSS should consider whether the caretaker's failure to provide necessary medical treatment was caused by ignorance or misunderstanding. The LDSS should consider whether the caretakers obtained accredited medical assistance and were aware of the seriousness of their child's condition. The LDSS should weigh the possibility of a cure if a certain mode of treatment is undertaken and whether the caretakers provided their child with a treatment. The LDSS should consider whether the caretakers sought an alternative treatment recommended by their physician and have not totally rejected all responsible medical authority.
- **Assess financial capabilities and poverty.** The LDSS should consider whether the caretaker's failure to provide necessary medical treatment was caused by financial reasons or poverty.

Parents or caretakers should not be considered neglectful for the failure to provide necessary medical treatment unless they are financially able to do so or were offered financial or other reasonable means to do so. In such situations, a founded disposition may be warranted if, after appropriate counseling and referral, the parents still fail to provide the necessary medical care.

3.5.2.3.6 Child under alternative treatment

([22 VAC 40-705-30 C1](#)). A child who, in good faith, is under treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination pursuant to [§ 63.2-100](#) of the Code of Virginia, shall not for that reason alone be considered a neglected child.

The Code of Virginia provides that no child shall be considered an abused or neglected child only for the reason that the child is under treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination. The religious exemption to a founded disposition of child abuse or neglect mirrors the statute providing a religious defense to criminal child abuse and neglect.¹ This exemption means that a founded disposition cannot be based only upon the religious practices of the parents or caretakers. A founded disposition can be rendered for other reasons. For example, if the parent caused the injury in the first place, the religious exemption would not apply. The religious exemption to a founded disposition of abuse or neglect is designed to protect a family's right to freedom of religion. The religious exemption statute is not to provide a shield for a person to abuse or neglect a child.²

Should there be question concerning whether a child is under the treatment in accordance with a tenet or practice of a recognized church or religious denomination, the LDSS should seek the court's assistance. The court should decide whether the parent or caretaker is adhering to religious beliefs as the basis for refusal of medical or dental treatment.

¹ See [§ 18.2-371.1C](#) of the Code of Virginia. Any parent, guardian or other person having care, custody, or control of a minor child who in good faith is under treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination shall not, for that reason alone, be considered in violation of this section.

² The United States Supreme Court held in 1944 that "parents may be free to become martyrs themselves. But it does not follow that they are free, in identical circumstances, to make martyrs of their children before they can reach the age of full and legal discretion when they can make that choice for themselves." *Prince v. Massachusetts*, 321 U.S. 158, 170 (1944).

3.5.2.3.7 Medical neglect of infants with life-threatening conditions

The Virginia Administrative Code [22 VAC 40-705-30 C](#) states that medical neglect includes withholding of medically indicated treatment. The definition section of [22 VAC 40-705-10](#) et seq. defines withholding of medically indicated treatment as specific to infants. When conducting an investigation involving an infant deprived of necessary medical treatment or care, the LDSS must be aware of the ancillary definitions and guidance requirements.

[\(22 VAC 40-705-10\)](#). “Withholding of medically indicated treatment” means the failure to respond to the infant’s life-threatening condition by providing treatment (including appropriate nutrition, hydration, and medication) which in the treating physician’s or physicians’ reasonable medical judgment will be most likely to be effective in ameliorating or correcting all such conditions.

This definition applies to situations where parents do not attempt to get a diagnosis even when the child's symptoms are severe and observable.

- **Withholding of medically indicated treatment when treatment is futile.**

[\(22 VAC 40-705-30 C 2\)](#). For the purposes of this regulation, “withholding of medically indicated treatment” does not include the failure to provide treatment (other than appropriate nutrition, hydration, or medication) to an infant when in the treating physician’s or physicians’ reasonable medical judgment:

- a. The infant is chronically and irreversibly comatose;
- b. The infant has a terminal condition and the provision of such treatment would:
 - (1) Merely prolong dying;
 - (2) Not be effective in ameliorating or correcting all of the infant’s life-threatening conditions;
 - (3) Otherwise be futile in terms of the survival of the infant; or
 - (4) Be virtually futile in terms of the survival of the infant and the treatment itself under such circumstances would be inhumane.

- **Definition of chronically and irreversibly comatose and terminal condition.**

[\(22 VAC 40-705-10\)](#). “Chronically and irreversibly comatose” means a condition caused by injury, disease or illness in which a patient has suffered a loss of consciousness with no behavioral evidence of self-awareness or awareness of surroundings in a learned manner other than reflexive activity of muscles and nerves for low-level conditioned response and from which to a reasonable degree of medical probability there can be no recovery.

([22 VAC 40-705-10](#)). “Terminal condition” means a condition caused by injury, disease or illness from which to a reasonable degree of medical probability a patient cannot recover and (i) the patient’s death is imminent or (ii) the patient is chronically and irreversibly comatose.

3.5.2.4 Question 4: Does the LDSS have jurisdiction to conduct the family assessment or investigation?

The Code of Virginia [§ 63.2-1503 A](#) provides the LDSS with the jurisdictional authority to conduct investigations of reports or complaints alleging child abuse and neglect. Jurisdiction determines which LDSS has primary responsibility for responding to a valid complaint or report of abuse or neglect. The VAC addresses the issue of jurisdiction:

([22 VAC 40-705-50 B 3](#)). The local department receiving the complaint or report is a local department of jurisdiction.

The VAC further defines jurisdiction as:

([22 VAC 40-705-10](#)). "Local department of jurisdiction" means the local department in the city or county in Virginia where the alleged victim child resides or in which the alleged abuse and/or neglect is believed to have occurred. If neither of these is known, then the local department of jurisdiction shall be the local department in the county or city where the abuse and/or neglect was discovered.

The LDSS that first receives a report must ensure that the complaint or report is either determined valid and therefore conducts a family assessment or investigation or the agency receiving the report determines which is the appropriate agency of jurisdiction and transfers the information to that agency immediately, first placing a call of notification to the receiving agency. In determining jurisdiction, the LDSS receiving the complaint or report alleging abuse or neglect is the LDSS in the county or city where:

- The alleged victim child resides, or
- The alleged abuse or neglect is believed to have occurred, or
- If neither of the above is known, where the alleged abuse/neglect was discovered.

3.5.2.4.1 Lack of jurisdiction not sufficient to invalidate complaint or report

If an LDSS receives a complaint or report alleging abuse or neglect and the complaint is invalid solely because the LDSS lacks jurisdiction, then the LDSS must transfer the complaint or report to the LDSS with proper jurisdiction. If the complaint or report belongs out of state, then the LDSS must make a referral to the appropriate agency in the other state.

3.5.2.4.2 The LDSS first receiving the complaint or report shall ensure complaint or report, if valid, receives a response

([22 VAC 40-705-40 H 1](#)). The local department of jurisdiction that first receives a complaint or report of child abuse and/or neglect shall assume responsibility to ensure that a family assessment or an investigation is conducted.

The VAC specifically places responsibility on the LDSS who first receives the complaint or report alleging abuse or neglect to ensure that a family assessment or investigation is conducted if the complaint or report is valid. The purpose of this section is to ensure that a valid report or complaint does not go uninvestigated because of a question of jurisdiction.

3.5.2.4.3 Transfer jurisdiction of complaint to another LDSS

[22 VAC 40-705-40 H 1](#) requires the LDSS of jurisdiction first receiving a valid complaint to ensure that the complaint receives a family assessment or investigation. The LDSS first receiving the complaint must forward all information related to the complaint. The LDSS first receiving the complaint must also ensure that the other LDSS is going to conduct a family assessment or an investigation. The LDSS transferring the report to another LDSS must document the transfer in the automated data system.

3.5.2.4.4 Responsibilities of LDSS receiving the complaint

The LDSS to which the report is being transferred should inform the original LDSS whether they will or will not conduct the family assessment or investigation. If an LDSS refuses, that LDSS must immediately inform the requesting LDSS and document the reasons why the LDSS cannot assume primary responsibility for the family assessment or investigation. If the LDSS cannot agree as to who should assume the primary responsibility, then a CPS Regional Consultant should be contacted immediately. Regardless, the responsibility for ensuring a response remains with the LDSS that first receives the valid complaint.

3.5.2.4.5 Assistance between LDSS of jurisdiction

([22 VAC 40-705-40 H 2](#)). A local department may ask another local department which is a local department of jurisdiction to assist in conducting the family assessment or investigation. If assistance is requested, the local department shall comply.

An LDSS may ask another LDSS of jurisdiction to assist in conducting the CPS family assessment or investigation. Assistance shall be provided upon request. Assistance may include conducting courtesy interviews of the alleged victim child, the alleged victim child's parents or other caretakers, and the alleged abuser or neglector. Assistance may also include arranging for appointments, scheduling meetings, counseling sessions, or any other professional contacts and services for the alleged victim child and siblings, the child's parents or other caretakers, or alleged abuser or neglector.

- **When a party relocates outside of the investigating LDSS's jurisdiction.** The Code of Virginia [§ 63.2-1503 H](#) specifically addresses the circumstances when a party to a report or complaint of abuse or neglect relocates outside of the jurisdiction of the investigating LDSS.
- When the alleged victim child, and/or the child's parents or other caretakers who are the subject of the family assessment or investigation relocate out of the jurisdiction of the LDSS responsible for the family assessment or investigation, the LDSS of jurisdiction shall notify the CPS Unit of the LDSS where the parties relocated, whether inside or outside of Virginia. The LDSS of jurisdiction may seek assistance from the other LDSS in completing the investigation. The notified LDSS shall respond to the receiving LDSS's request for assistance in completing the family assessment or investigation. Any LDSS in Virginia so requested shall comply.
- **LDSS shall share relevant case record information.** When one LDSS requests another LDSS to assist in completing a family assessment or an investigation or providing services, the requesting LDSS shall contact the receiving LDSS by telephone before transferring the record within the child abuse and neglect information system. The receiving LDSS shall then arrange protective and rehabilitative services as needed or appropriate, and assist in a timely completion of the investigation. All written notification and letters (i.e., disposition letters and notification of appeal rights) remain the responsibility of the original LDSS of jurisdiction conducting the family assessment or investigation. The LDSS of jurisdiction shall continue to retain case materials not entered into the automated data system and

provide the receiving LDSS with relevant portions of the case record necessary to provide services or to complete the investigation or family assessment.

([22 VAC 40-705-40 H3](#)). A local department may ask another local department through a cooperative agreement to assist in conducting the family assessment or investigation.

- **Cooperative agreements between LDSS.** An LDSS may request assistance from an LDSS that is not a primary LDSS of jurisdiction. When one LDSS requests assistance from a neighboring locality in completing a family assessment or an investigation, both LDSS shall develop a cooperative agreement in which the specific request, parameters, follow-up requirements, and related topics are addressed.

3.5.2.4.6 The appearance of a conflict of interest

Family assessments or investigations involving recognized figures, local or county officials, former employees, and other persons who are well known within the community may raise the appearance of a conflict of interest for an LDSS.

In order to assure that the response to such cases is and appears to be impartial, the LDSS of jurisdiction may contact a neighboring locality and develop the appropriate guidelines for completion of the family assessment or investigation. The LDSS must develop a cooperative agreement to ensure that the report receives an appropriate response.

The LDSS should request a neighboring locality to assume jurisdiction and conduct any investigation in reports involving a foster child when the child is placed in a locally approved foster home.

When considering transferring a report or complaint of child abuse or neglect because of the appearance of a conflict of interest, the LDSS may seek guidance from the CPS Regional Consultant.

3.5.2.4.7 Family assessments or investigations involving employees of LDSS

The Code of Virginia [§ 63.2-1509](#) provides the juvenile and domestic relations district court the authority to determine jurisdiction of the investigation if the alleged abuser or neglecter is an employee of the LDSS where the report or complaint was received. The purpose of this statute is to ensure a fair investigation and preserve impartiality.

The VAC states:

([22 VAC 40-705-40 H4](#)). If a local department employee is suspected of abusing and/or neglecting a child, the complaint or report of child abuse and/or neglect shall be made to the juvenile and domestic relations district court of the county or city where the alleged abuse and/or neglect was discovered. The judge shall assign the report to a local department that is not the employer of the subject of the report pursuant to §§ [63.2-1509](#) and [63.2-1510](#) of the Code of Virginia.

- **Jurisdiction: assignment of investigation by court to LDSS.** If a LDSS is assigned a report by the court, the family assessment or investigation should be conducted like any other.

3.5.2.4.8 LDSS cannot assume jurisdiction if abuse or neglect occurred in another state and the alleged abuser does not reside in Virginia

A LDSS shall not assume jurisdiction of an investigation or family assessment if the alleged abuse or neglect occurred in another state and the alleged abuser does not reside in Virginia, even if the alleged victim resides in Virginia at the time of the report. A LDSS should report the suspected abuse or neglect to CPS in the state where the abuse or neglect occurred. If the other state requests assistance in conducting the investigation or family assessment, the LDSS should comply. If services are needed for the child or family, the LDSS may open the case for services.

- **Transfer jurisdiction of investigation to another state.** If appropriate, the LDSS may request the other state to assume jurisdiction of the investigation. If the other state agrees to assume jurisdiction of the investigation, the LDSS should provide all information relevant to the investigation to the other state. The following information should be provided when making a referral:
 - The name, date of birth, and sex of child.
 - Any other name by which the child may be known.
 - The names of parent and/or guardian.
 - Any other names by which the parent and/or guardian may be known.
 - The current address including any directions.
 - Last known address.

- Statement of why the referral is being made.
- Brief social history of the child and the family.
- A brief description of the LDSS's involvement with the family.

If the other state refuses to accept jurisdiction, then the LDSS must determine whether sufficient resources are available to conduct a thorough family assessment or investigation. The LDSS may not be able to gather sufficient evidence to make a determination of whether the abuse or neglect occurred. The LDSS must clearly document in the record if the LDSS is unable to conduct the family assessment or investigation or unable to gather sufficient evidence to make a determination. The automated data system should be notified that the LDSS was unable to complete the response.

3.5.3 Universal screening for domestic violence (DV)

All valid reports should be screened to determine the presence of DV. There are several evidence based tools that can be used to screen for DV depending on who is being interviewed. The "HITS" (Hurt, Insult, Threaten, Scream) screening tool may be used to screen for DV with collaterals such as family members, professionals, service providers, anonymous callers and mandated reporters. The Women's Experience with Battering Tool (WEB) is designed to be used with potential victims of DV. These screening tools and additional guidance regarding DV and universal screening can be found in a new section of the [VDSS Child and Family Services Manual, Chapter H. Domestic Violence](#).

3.5.4 Invalid report or complaint

([22 VAC 40-705-50 C](#)). The local department shall not conduct a family assessment or investigate complaints or reports of child abuse and/or neglect that fail to meet all of the criteria in subsection B of this section.

Each of the four criteria outlined in [22 VAC 40-705-50 B](#) must be satisfied in order to achieve a valid complaint of abuse or neglect requiring a family assessment or an investigation. If the complaint or report of abuse or neglect fails to meet any one of the criteria, then the complaint or report is not valid and the LDSS has no authority to conduct a CPS family assessment or an investigation.

3.5.4.1 Additional information for screening reports of abuse/neglect regarding public school personnel

The Code of Virginia [§ 63.2-1511](#) states that "reasonable and necessary" force should be taken into account in determining validity of reports of abuse or neglect by public school employees. Appendix A in Section 5:Out of Family Investigations of this guidance manual has additional guidance for assessing

the applicability of § [63.2-1511](#) for CPS out-of-family reports of school employees.

3.5.4.2 Screening consideration if alleged abuser is deceased

If the alleged abuser or neglector is deceased at the time of the report or dies during the course of the investigation, the LDSS must evaluate whether the purpose of the investigation would be achieved. An investigation may be appropriate if there is a child victim in need of services or in order to prevent other abuse or neglect.

3.5.4.3 Prevention response for invalid report or complaint

If a report or complaint is determined to be invalid and the LDSS has determined that services need to be provided to prevent foster care, the LDSS should open a Prevention services case to provide services to the child and family. The Code of Virginia § [63.2-905](#) provides the legal authority to offer and provide foster care services, which includes services to a child who is in need of services to prevent or eliminate the need for foster care placement. A child in need of services may include a victim of sex trafficking or non-caretaker sexual abuse.

(§ [63.2-905](#) of the Code of Virginia). Foster care services are the provision of a full range of casework, treatment and community services, including but not limited to independent living services, for a planned period of time to a child who is abused or neglected as defined in § [63.2-100](#) or in need of services as defined in § [16.1-228](#) and his family when the child (i) has been identified as needing services to prevent or eliminate the need for foster care placement, (ii) has been placed through an agreement between the local board or the public agency designated by the community policy and management team and the parents or guardians where legal custody remains with the parents or guardians, or (iii) has been committed or entrusted to a local board or licensed child placing agency. Foster care services also include the provision and restoration of independent living services to a person who is over the age of 18 years but who has not yet reached the age of 21 years, in accordance with § [63.2-905.1](#).

Refer to the VDSS Child and Family Services Manual, [Chapter B. Prevention, Section 4](#), for further guidance regarding prevention services. See [Appendix I of Section 6, Services](#) in this manual for additional information about services for victims of sex trafficking.

3.5.5 Required notifications if report or complaint is invalid

3.5.5.1 Notify complainant

If a report is determined to be invalid, the LDSS must inform the complainant of its lack of authority to take action.

3.5.5.1.1 Invalid complaint involving child care facility

If a report is not valid because it addresses general substandard conditions in a child care facility (such as quality of food or program issues in a day care setting or residential facility), but the conditions do not constitute abuse or neglect, the LDSS shall identify the proper regulatory authority and refer the caller to that regulatory authority. If there is no regulatory authority and no valid complaint for CPS investigation, the caller shall be informed that there is no agency with the authority to intervene.

3.5.5.1.2 Non-caretaker sexual abuse: information to be provided to reporter or complainant

The intake worker should explain the following to the person making the report or complaint alleging the non-caretaker sexual abuse of a child:

- The LDSS is not the agency authorized to investigate the report.
- The LDSS is required to report this information directly to law enforcement.

This includes allegations involving sex trafficking of a child by someone not in a caretaker role.

3.5.5.2 Notify law enforcement of non-caretaker sexual abuse

If a report is not valid because it alleges child sexual abuse perpetrated by a person who is not in a caretaker role, the LDSS is required to report the allegation to the local law enforcement agency. The worker should telephone the information to law enforcement in the jurisdiction where the abuse occurred in accordance with any local protocol or standard procedures for reporting sex offenses involving juvenile victims. If there is any reason to believe a child may be in danger, the report must be made immediately. In all other cases, the report must be made on the **same day** it is received. Additional procedures may be developed locally to ensure effective reporting and accountability.

3.5.5.3 Information to provide to law enforcement in non-caretaker sexual abuse

The intake worker should attempt to obtain as much information about the alleged sexual abuse as possible and forward that information to the local law enforcement agency. The intake worker should attempt to obtain the following information:

- The identity of the child and the identity of the alleged perpetrator (name, birth date, sex, address, child's school).
- Brief description of the alleged abuse.

3.6 Certain complaints shall be reported to the CA and others

3.6.1 Report certain cases of suspected child abuse or neglect

([22 VAC 40-705-50 D](#)). The local department shall report certain cases of suspected child abuse or neglect to the local attorney for the Commonwealth and the local law-enforcement agency pursuant to [§ 63.2-1503 D](#) of the Code of Virginia.

The following complaints and reports shall be reported by the LDSS to the attorney for the Commonwealth and local law enforcement agency **immediately but within two (2) hours** of receipt of the report. The LDSS shall provide records and information, including reports related to any complaints of abuse or neglect involving the victim(s) or the alleged perpetrator, related to the investigation of the complaint. The LDSS must document the date and time of notification to the local attorney for the Commonwealth and the local law enforcement agency in the automated data system. This notification should be documented on the referral acceptance screen and in the referral as an Interview and Interaction (I and I).

3.6.1.1 Any death of a child

Any report or complaint alleging the death of a child as a result of abuse or neglect shall be immediately reported to the local attorney for the Commonwealth and the local law-enforcement agency.

See [Section 11](#), Child Deaths, of this guidance manual for additional requirements and guidance related to a report of a child death due to suspected abuse or neglect.

3.6.1.2 Any injury or threatened injury to a child involving a felony or Class I misdemeanor

Any report or complaint involving an injury (actual or threatened) that may have occurred as the result of a commission of a felony or a Class 1 misdemeanor

shall be immediately reported to the local attorney for the Commonwealth and the local law-enforcement agency. Felony offenses are punishable with death or confinement in a state correctional facility; all other offenses are misdemeanors.³

Felonies are classified, for the purposes of punishment and sentencing, into six classes; misdemeanors are classified into four classes.⁴

3.6.1.3 Any sexual abuse, suspected sexual abuse or other sexual offense involving a child

Any sexual abuse, suspected sexual abuse, or other sexual offense involving a child, including but not limited to the use or display of the child in sexually explicit visual material, as defined in the Code of Virginia [§ 18.2-374.1](#) et seq., shall be reported to the local attorney for the Commonwealth office and local law enforcement agency. *This includes criminal acts of commercial sex trafficking as defined in the Code of Virginia [§18.2-357.1](#).*

3.6.1.4 Any abduction of a child

Any time a report or complaint alleges the abduction of a child, the LDSS shall make a report to the local attorney for the Commonwealth office and to local law enforcement agency.

3.6.1.5 Any felony or Class 1 misdemeanor drug offense involving a child

Any time a report or complaint alleges abuse or neglect of a child and the commission of a felony or a Class 1 misdemeanor drug offense, the LDSS shall notify the local attorney for the Commonwealth office and local law enforcement agency.

3.6.1.6 Contributing to the delinquency of a minor

Contributing to the delinquency of a minor in violation of the Code of Virginia [§ 18.2-371](#) shall be reported to the local attorney for the Commonwealth office and local law enforcement agency.⁵

³ [§ 18.2-8](#), of the Code of Virginia.

⁴ [§ 18.2-9](#) of the Code of Virginia.

⁵ The Code of Virginia [§ 18.2-371](#) defines contributing to the delinquency of a minor as:

Any person 18 years of age or older, including the parent of any child, who (i) willfully contributes to, encourages, or causes any act, omission, or condition which renders a child delinquent, in need of services, in need of supervision, or abused or neglected as defined in [§16.1-228](#), or (ii) engages in consensual sexual intercourse with a

3.6.1.7 Information to provide to Commonwealth's Attorney and law-enforcement agency

When making a report to the local attorney for the Commonwealth and local law enforcement agency, the LDSS shall make available all of the information upon which the report is based, including the name of the complainant and records of any complaint of abuse or neglect involving the victim or the alleged perpetrator.

3.6.1.8 Other criminal acts related to child abuse or neglect

Other felonies and misdemeanors, not specifically identified for reporting by the Code of Virginia, may be related to child abuse or neglect. The reporting of these offenses must be in accordance with guidance developed by the LDSS in conjunction with the community's law enforcement and judicial officials.

3.6.2 Notification to law enforcement form

Written notification by the LDSS to the local law enforcement agency shall be made within **two (2) business days** of receipt of the report by the LDSS and shall be documented on the Notification to Law Enforcement from Child Protective Services form located in [Appendix C](#). The form is also available on the public [VDSS website](#) under forms. The notification form shall be signed by the LDSS representative making the notification and the law enforcement agency representative receiving the notification. The form and signatures may be completed electronically or in writing.

3.6.3 Memoranda of understanding with law enforcement and Commonwealth's attorney

The Code of Virginia [§ 63.2-1503 J](#) and the Virginia Administrative Code state:

[\(22 VAC 40-705-50 E\)](#)... local departments shall develop, where practical, memoranda of understanding for responding to reports of child abuse and neglect with local law enforcement and the local office of the commonwealth's attorney.

Since many situations are required to be reported to local law enforcement and/or the attorney for the Commonwealth, children and families will be better served if there is an understanding between these organizations and the LDSS. It is recommended that these agencies develop a written agreement regarding how varied situations will be handled, how communications should flow, etc. Provisions for roles and responsibilities of all parties, cross-training of staff, updating the agreement, and resolving problems are other examples of what the agreement

child 15 or older not his spouse, child, or grandchild, is guilty of a Class 1 misdemeanor. This section shall not be construed as repealing, modifying, or in any way affecting [§§18.2-18](#), [18.2-19](#), [18.2-61](#), [18.2-63](#), and [18.2-347](#).

should include in order for it to be an effective and continuous agreement among these agencies that are so vital to the protection of children.

3.7 Report Child Fatalities and Near Fatality

3.7.1 Report a child fatality

([22 VAC 40-705-50 F](#)). The local department shall report to the following when the death of a child is involved:

1. When abuse and/or neglect is suspected in any case involving the death of a child, the local department shall report the case immediately to the regional medical examiner pursuant to [§ 63.2-1503 E](#) of the Code of Virginia.
2. When abuse and/or neglect is suspected in any case involving the death of a child, the local department shall report the case immediately to the attorney for the Commonwealth and the local law enforcement agency pursuant to [§ 63.2-1503 D](#) of the Code of Virginia.
3. The local department shall contact the department immediately upon receiving a complaint involving the death of a child and at the conclusion of the investigation.

The VAC requires the LDSS to immediately contact the Regional [Medical Examiner](#), attorney for the Commonwealth, local law enforcement, and the CPS Regional Consultant when a report or complaint alleging abuse or neglect involves the death of a child.

The LDSS must document the notifications in the automated data system.

See [Section 11, Child Deaths](#), of this guidance manual for additional requirements and guidance related to a report of a child death due to suspected abuse or neglect.

3.7.2 Report "near fatality" of a child

The [Child Abuse and Prevention Treatment Act](#) (CAPTA) defines a "near fatality" as an act that, as certified by a physician, places the child in serious or critical condition. The VAC provides the following definitions:

([22 VAC 40-910-10](#)) "Near fatality" means an act that, as certified by a physician, places the child in serious or critical condition. Serious or critical condition is a life-threatening condition or injury.

([22VAC40-705-10](#)) "Life-threatening condition" means a condition that if left untreated more likely than not will result in death and for which the recommended medical treatments carry a probable chance of impairing the health of the individual or a risk of terminating the life of the individual.

Inherent within the definition of a near fatality is the requirement that a physician certify that the child is in serious or critical condition at the time of the report.

Certification by a physician can be either in writing or verbal. Hospital records which indicate the child's condition is serious or critical and life threatening are sufficient. The physician certification must be documented in the automated data system.

Some questions the LDSS can ask the physician to help determine if the child's condition is a near fatality include, but are not limited to:

- Are the child's vital signs unstable?
- Is the child ill or unconscious?
- Is the outcome questionable or unfavorable?
- Does the child require hospitalization in an intensive care unit?
- Does the child require significant intervention in terms of airway management, ventilatory support and fluid, or medication resuscitation?

3.7.2.1 Examples of a near fatality of a child

Some examples of a near fatality by type of abuse or neglect include:

- **Physical Abuse:** A child has been diagnosed with Abusive Head Trauma and has been admitted to the Intensive Care Unit of the hospital. The attending physician has indicated the child's prognosis is poor and the child is in critical condition.
- **Physical Neglect:** A child overdoses on the caretaker's psychotropic medication that had not been stored properly. The child is in a coma and the doctor reports the child may die.
- **Physical Neglect (FTT):** A child is admitted to the pediatric intensive care unit due to significant weight loss and possible malnutrition. The doctor has diagnosed the child as non-organic Failure to Thrive and states the child is seriously ill.
- **Medical Neglect:** A child with diabetes is admitted to the hospital due to medical complications directly related to the caretakers not following the prescribed medical treatment (giving the child their insulin). The hospital records indicate the child presented in a life threatening condition.

3.7.2.2 Notification and documentation of near fatalities

The LDSS must inform the CPS Regional Consultant as soon as possible of all situations which constitute a near fatality and document the notification in the automated data system.

The LDSS must document situations which constitute a near fatality of a child in the automated data system in conjunction with the type of abuse or neglect that is alleged to have caused the near fatality.

If during the course of the investigation the child dies, the automated data system must be changed to reflect the fatality. A child cannot be considered a near fatality and a fatality.

Additional guidance on disclosing near fatality information and findings can be located in Section 11, Child Deaths, of this guidance manual.

3.8 Screen valid complaints and reports for priority

The LDSS must consider and analyze all the information collected at the time of the referral to determine the most appropriate response to initiate a family assessment or investigation based on the child's immediate safety or other factors.

The LDSS determines urgency of response time for valid reports by completing the response priority decision trees in the CPS Intake Tool documented in the automated data system. The response priority decision trees are designed to assist in determining how quickly to initiate the response. Selections made on the response priority decision trees must relate to supporting narrative in the automated data system.

Timeliness of the initial response is calculated from the date and time of the referral. There are three (3) response levels:

- Response 1 (R1): as soon as possible **within 24 hours** of the date and time of the referral
- Response 2 (R2): as soon as possible **within 48 hours** of the date and time of the referral
- Response 3 (R3): as soon as possible **within five working days** of the date and time of the referral

All decisions to override the response level must be approved by the supervisor and documented in the automated data system. Copies of the CPS Intake Tool and definitions are located on the forms webpage on the [DSS public website](#) and in [Appendix D](#). Since determining urgency of response is critical for valid reports, the following guidance is provided:

([22 VAC 40-705-50 G](#)): Valid complaints or reports shall be screened for high priority based on the following:

1. The immediate danger to the child;
2. The severity of the type of abuse or neglect alleged;

3. The age of the child;
4. The circumstances surrounding the alleged abuse or neglect;
5. The physical and mental condition of the child; and
6. Reports made by mandated reporters.

3.8.1 The immediate danger to the child

The following information should be gathered, when possible, and should be evaluated in addition to the specifics of the complaint:

- Is the child in current distress, injured, or otherwise in an unsafe environment?
- What plans do the caretakers have for the future or continued protection of the child?
- Has the abuse or neglect diminished or stopped, or is the child thought to be at risk of continued abuse or neglect?
- Is the living situation immediately dangerous?
- Is any child currently left unsupervised who is age 8 or under or too disabled to care for self?
- Is the caretaker not available and no provision made for child's care?
- Is law enforcement requesting immediate response?
- Will perpetrator have access to child in next 48 hours?
- Are severe parental or caretaker substance abuse, developmental disabilities, or mental illness issues present AND no other appropriate caretaker is present?
- Does child's behavior put self at risk and caretaker does not respond appropriately?
- Is the child in an alternative safe environment?
- Has a substantial amount of time passed since the incident occurred?

3.8.2 The severity of the type of abuse or neglect alleged

The following information should be gathered, when possible, and should be evaluated in addition to the specifics of the complaint:

- Are there allegations or evidence of broken bones, fractures, cuts, broken skin, severe bruising, or serious maltreatment?
- Were instruments or other items, such as guns, knives, or belts, used in the infliction of the abuse or neglect?
- Is the neglect or abuse of a continuing or chronic nature? Is there evidence establishing a pattern of abusive or neglectful behavior?
- Is the threat of abuse or neglect imminent?
- Can the caretaker be located? Is the caretaker not available?
- Is it likely that the precipitating event or one similar will reoccur?
- Are factors in the environment (both in and outside the home) observed to have an impact on the actual or threat of harm to the child?
- Were severe or bizarre disciplinary measures used, or was abuse premeditated?
- Is medical care required; or are significant bruises, contusions, or burns evident?
- Is caretaker's behavior toward child extreme, severe, or bizarre?

3.8.3 The age or vulnerability of the child

The following information should be gathered, when possible, and should be evaluated in addition to the specifics of the complaint:

- Does the child's age, sex, developmental level, chronological age, or maturation level effect the child's vulnerability to abuse or neglect?
- What is the child's capacity to protect him or herself from future abuse or neglect?
- Is the child able to express thoughts or responses regarding the allegation of abuse or neglect?

- Is the child currently alone with, or repeatedly left alone with, a non-related violent sex offender?
- Does information show observable and substantial impairment in child's ability to function in a developmentally appropriate manner?

3.8.4 The circumstances surrounding the alleged abuse or neglect

The following information should be gathered, when possible, and should be evaluated in addition to the specifics of the complaint:

- Who is responsible for the abuse or neglect?
- What is being reported?
- When did the abuse or neglect occur?
- Where did the abuse or neglect occur?
- Were other individuals aware or witness to the circumstances of the abuse or neglect?
- Are siblings of the victim child aware or witness to the abuse or neglect?
- Did the abuse or neglect occur during a punishment or instructional contact with the child?
- What is the likelihood that the circumstances leading to the abuse or neglect will reoccur?
- Is the allegation exposure to drug-related activity and/or involves a meth lab?
- Is the family about to flee or have a history of fleeing?
- Is non-involved caretaker's response appropriate and protective of child?
- Is non-involved caretaker unaware of abuse or is the response to abuse unknown?
- Does perpetrator have access, or is child afraid to go home?

3.8.5 The physical and mental condition of the child

The following information should be gathered, when possible, and should be evaluated in addition to the specifics of the complaint:

- Is the child thought to be of normal development and possess the ability to communicate during the investigation?
- Are there known illnesses, developmental delays, or other impediments to normal growth and development of the victim child?
- Does the child's perception of his role impact his or her vulnerability for abuse or neglect?
- Does child appear seriously ill or injured and in need of immediate medical care?
- Is any child age eight (8) or under or limited by disability?

3.8.6 Complaints made by mandated reporters

The following information should be gathered, when possible, and should be evaluated in addition to the specifics of the complaint:

- When was the mandated reporter made aware of the circumstances involving the alleged abuse or neglect?
- In what capacity did the mandated reporter know the alleged victim child? What was the relationship between the alleged victim child and the mandated reporter?
- Has the mandated reporter discussed the circumstances with the child? With the parents? Other professionals?
- Does the mandated reporter possess other relevant information such as knowledge about the living conditions or other environmental factors?
- What actions or services are recommended by the mandated reporter?

3.8.7 Initiating a response to a valid report

Timeliness of the initial response is calculated from the date and time when the referral is received. The initial response is the first attempted or completed contact with the alleged victim, parent/caretaker, or collateral. The LDSS should make a face-to-face contact with the alleged victim child **within the initial response priority level assigned**, as this contact is critical. Sometimes the LDSS's initial efforts to respond to the report will not be successful such as when no one is home. In other situations, the LDSS's first contact, although not with the victim child, does provide information to assess child safety. Sometimes the initial response may be by telephone with the victim, the parent, or collateral that provides information to begin

the family assessment or investigation and contributes to the initial child safety assessment.

Initial response may or may not be the same as first meaningful contact. See Section 4, Family Assessment and Investigation, of this guidance manual for further guidance on first meaningful contact and initial safety assessment.

All contacts, attempted or completed, in the family assessment and investigation must be entered into the automated data system to document the LDSS's response to the report and to document compliance with CPS program requirements. This includes documentation of all attempted contacts as well as case planning that affect the initiation of the family assessment or investigation.

3.9 Determine the appropriate response: family assessment or investigation

The Code of Virginia [§ 63.2-1503 I](#) authorizes the LDSS to determine validity of a complaint or report. For all valid complaints or reports, the LDSS shall determine whether to conduct a family assessment or an investigation.

After the decisions regarding validity and urgency, a decision must be made as to whether to conduct a family assessment or an investigation. Certain complaints or reports are required by the Code of Virginia to be investigated.

[\(22 VAC 40-705-50 H\)](#). The local department shall initiate an immediate response. The response shall be a family assessment or an investigation. Any valid report may be investigated, but in accordance with [§ 63.2-1506 C](#) of the Code of Virginia, the following shall be investigated: (i) sexual abuse, (ii) a child fatality, (iii) abuse or neglect resulting in a serious injury as defined in [§ 18.2-371.1](#), (iv) a child has been taken into the custody of the local department of social services, or (v) a caretaker at a state-licensed child day care center, religiously exempt child day center, regulated family day home, private or public school, or hospital or any institution.

[\(§ 18.2-371.1 A](#) of the Code of Virginia) Any parent, guardian, or other person responsible for the care of a child under the age of 18 who by willful act or omission or refusal to provide any necessary care for the child's health causes or permits serious injury to the life or health of such child shall be guilty of a Class 4 felony. For purposes of this subsection, "serious injury" shall include but not be limited to (i) disfigurement, (ii) a fracture, (iii) a severe burn or laceration, (iv) mutilation, (v) maiming, (vi) forced ingestion of dangerous substances, or (vii) life-threatening internal injuries.

3.9.1 Make the response track decision

Family assessments are conducted when the concerns outlined in the report indicate inadequate parenting or life management rather than dangerous parenting practices and actions. The VAC defines family assessment as follows:

([22 VAC 40-705-10](#)). “Family assessment” means the collection of information necessary to determine:

1. The immediate safety needs of the child;
2. The protective and rehabilitative services needs of the child and family that will deter abuse or neglect;
- 3 Risk of future harm to the child; and
4. Alternative plans for the child’s safety if protective and rehabilitative services are indicated and the family is unable or unwilling to participate in services. These arrangements may be made in consultation with the caretaker(s) of the child.

An investigation is conducted when the allegations in the report are required by statute or indicates there is serious abuse or neglect resulting in immediate or impending harm to the child. The VAC defines an investigation as follows:

([22 VAC 40-705-10](#)).

"Investigation" means the collection of information to determine:

1. The immediate safety needs of the child;
2. The protective and rehabilitative services needs of the child and family that will deter abuse or neglect;
3. Risk of future harm to the child;
4. Alternative plans for the child’s safety if protective and rehabilitative services are indicated and the family is unable or unwilling to participate in services;
5. Whether or not abuse or neglect has occurred;
6. If abuse or neglect has occurred, who abused or neglected the child; and
7. A finding of either founded or unfounded based on the facts collected during the investigation.

The immediate danger to the child and the severity of the alleged abuse or neglect are crucial factors to be considered. This guidance is not intended to be all inclusive and does not replace the LDSS judgment regarding alleged safety threats and risk factors.

The LDSS completes the differential response decision on the CPS Intake Tool in the automated data system. This checklist and the definitions assist with consideration of statutory mandates for the investigation track and other serious situations which may be appropriate for the investigation track. The CPS Intake Tool is located on the [DSS public website](#) or in [Appendix D](#).

Additional guidance regarding track decisions when DV is involved can be found in section 1.4.4.2 of the [VDSS Child and Family Services Manual, Chapter H, Domestic Violence](#).

The following variables should be considered when determining the track. The LDSS should assign a report to the investigation track if one or more of the following variables are present:

- If there is a **third** valid CPS report within 12 months, it must be investigated.
- Type and severity of alleged abuse. Serious injuries as defined in [§ 18.2-371.1](#) are required by the Code of Virginia to be investigated. Those injuries include but are not limited to disfigurement, bone fractures, severe burns or lacerations, mutilation, maiming, forced ingestion of dangerous substances, and life-threatening internal injuries. A serious injury also includes brain damage, subdural hemorrhage or hematoma, dislocations, sprains, scalds or any other physical injury that seriously impairs the health or well-being of the child and requires medical treatment (e.g., suffocating, shooting, significant bruises/welts, bite marks, choke marks). Non-organic failure to thrive of an infant.
- Use of excessive physical discipline or physical force. This includes using torture or excessive physical force, or acting in a way that bears little resemblance to reasonable discipline given the child's age and stage of development; or caretaker punished child beyond the duration of the child's endurance. (e.g., punching child in head or stomach, tying child up, locking child in a closet, slamming child against wall, or punishing child in a way that produces humiliation or degradation, punishing child for acts that are outside child's control).
- History of abuse or neglect. Consider previous maltreatment by a caretaker that was serious enough to have caused a severe injury. Take into consideration if parental rights have been terminated on any other children as a result of prior child maltreatment.
- Caretaker failed to benefit from previous professional help. Consider if the caretaker previously maltreated a child in their care and was referred for services, but did not participate in or did not benefit from those services.
- Child's age and ability to self-protect. The age of the child is a critical factor since any abuse or neglect to a child six (6) years of age and under has the potential to constitute a serious and immediate safety threat to the child's health and safety. Consider the presence of a disability that affects the child's ability to self-protect regardless of age.

- Threaten to cause harm or retaliate against the child. Consider if there is a threatening action that would result in serious harm or a household member plans to retaliate against the child for CPS involvement. Consider whether or not the caretaker's behavior is violent or out of control.
- Living conditions. Child's physical living conditions are reported to be hazardous and immediately threatening, based on the child's age and developmental status. This includes reports indicating illegal drugs are being sold or manufactured in the home and unsecured weapons.
- Child's proximity to DV incident. Consider if the child was in immediate danger of serious physical harm by being in close proximity to an incident(s) of assaultive behavior/DV between adults in the household.
- If there is reason to believe that a child's safety will be jeopardized if parental cooperation cannot be obtained prior to interviewing the child.

If the allegations are not required by statute to be investigated or do not include any of the above variables, the report may be placed in the family assessment track.

The track decision should be made at intake, before responding, if at all possible.

If sufficient information cannot be obtained from the complainant, the track assignment can be made at the point of the first meaningful contact with any parties named in the complaint. Additional local criteria for track assignment may be developed, but the criteria must be consistently applied within the locality. The chart that follows is intended to assist local CPS staff in evaluating child abuse and neglect reports for placement in a response track.

3.9.2 CPS Report Placement Chart

FAMILY ASSESSMENT RESPONSE	INVESTIGATION RESPONSE
<p>No situations are mandated to be Family Assessments.</p> <p>(After a family has received two (2) valid CPS reports within 12 months, the third report must be investigated).</p>	<p>Mandated by Code of Virginia (§ 63.2-1506 C):</p> <ul style="list-style-type: none"> - All sexual abuse allegations - Any child fatality - Abuse or neglect resulting in serious injury as defined in § 18.2-371.1 * [also consider medical neglect of disabled infant with life threatening condition (Baby Doe)]; - Child taken into agency custody due to abuse or neglect (§ 63.2-1517) - Child taken into protective custody by physician or law enforcement, pursuant to § 63.2-1517 - All allegations regarding a caretaker in a designated out of family setting as defined in § 63.2-1506 C
	<p>Policy mandate: All allegations regarding a caretaker in an out of family setting of any kind, i.e. foster homes, day care, residential facilities.</p>
<p>Examples of when this response may be most appropriate:</p> <p>Physical Abuse: Abusive treatment of a child that may or may not have caused a minor injury – no medical treatment required.</p> <p>Mental Abuse: Child is experiencing minor distress or impairment; child’s emotional needs are sporadically met but there are behavioral indicators of negative impact. Child exposed to DV.</p> <p>Neglect: Lack of supervision where child is not in danger at time of report; minor injuries suggesting inattention to child safety.</p> <p>Substance Exposed Infant referrals.</p>	<p>Examples of when this response is most appropriate, but not mandated by law:</p> <p>Physical Abuse: Physical abuse that causes or threatens to cause serious injury (other than that defined in § 18.2-371.1*); or that may require medical evaluation, treatment or hospitalization. Reports of children present during the sale or manufacture of illegal substances; and highly recommend these be investigated jointly with law enforcement.</p> <p>Mental Abuse: Child is experiencing serious distress or impairment; child’s emotional needs allegedly are not being met or are severely threatened.</p> <p>Neglect: Lack of supervision that causes or may cause serious injury or illness; injury or threat of injury due to use of weapons in the home.</p> <p>Non-Organic Failure to Thrive: Child is an infant and at imminent risk of severe harm.</p> <p>Child Abandonment referrals.</p> <p>Third valid CPS report in 12 months</p>

* Note that § 18.2-371.1 A includes, but is not limited to, disfigurement, fracture, severe burns or lacerations, mutilation, maiming, forced ingestion of dangerous substances, or life threatening internal injuries.

3.10 Appendix A: Children home alone

Virginia state statutes do not set a specific age after which a child legally can stay alone.* Age alone is not a very good indicator of a child's maturity level. Some very mature 10-year-olds may be ready for self-care while some 15-year-olds may not be ready due to emotional problems or behavioral difficulties. In determining whether a child is capable of being left alone and whether a parent is providing adequate supervision in latchkey situations, CPS will assess several areas. These areas include:

- **Child's level of maturity.** CPS will want to assess whether the child **is physically capable** of taking care of himself; **is mentally capable** of recognizing and avoiding danger and making sound decisions; **is emotionally ready** to be alone; knows what to do and whom to call if an emergency arises; and has special physical, emotional, or behavioral problems that make it unwise to be left alone. **It is important to note that a child who can take care of him/herself may not be ready to care for younger children.**
- **Accessibility of those responsible for the child.** CPS will want to determine the location and proximity of the parents, whether they can be reached by phone and can get home quickly if needed, and whether the child knows the parents' location and how to reach them.
- **The situation.** CPS will want to assess the time of day and length of time the children are left alone; the safety of the home or neighborhood; whether the parents have arranged for nearby adults to be available in case a problem arises; and whether there is a family history of child abuse or neglect.

* Some localities have ordinances concerning the age at which a child may be left without supervision.

3.11 Appendix B: Distinguishing between accidental and non-accidental injury

One of the most critical responsibilities of child welfare staff during the investigation or review of a child's death is to distinguish between accidental and non-accidental injuries. This is particularly difficult when staff must distinguish between accidents in which chronic neglect or inadequate supervision was a factor and those where neglect is not a concern. In most cases, medical input will be required to make such a determination. These situations include those where the conditions resulting in the child's death appear to be directly created by or under the control of the parent or other person responsible for the child's care, yet the death is not identified as relating to a specific type of maltreatment, as well as those deaths that are alleged or known to have occurred as a result of abuse or neglect. Consideration of the following four (4) factors can provide guidance for this process:

- **Discrepant history.** In some cases, the nature of the injury does not match the history given by the parent or other person responsible for the child's care. To determine this requires a detailed description of the incident. What were the circumstances leading up to and following the incident? When did it occur? Who was present at the time of the incident? What were the specific medical assessment of how the injuries occurred and the detailed description of the injuries and the child's condition? What information was obtained during the onsite visit?
- **Delay in seeking medical care.** At times, the delay in seeking medical care can range from a few moments to hours. In assessing delay, it is important to realize, for example, that following a severe shaking or beating, the abuser will often place a child down in a crib or on the floor and leave the room. The child may then exhibit symptoms of intracranial pressure (vomiting, seizures, and cardio respiratory arrest). These symptoms then cause the person responsible for the abuse to contact emergency help, and that person often disassociates the symptoms from their previous actions.
- **Triggering event by the child(ren).** This is usually age-specific behavior, such as inconsolable crying, a messy diaper, toilet training problems, etc., which triggers the abuse.
- **A crisis in the family.** A crisis may have placed additional stress on the family's capacity to cope. Crisis can take the form of unexpected or difficult pregnancy, marital differences, loss of job, or death of an extended family member.

3.12 Appendix C: Notification to Law Enforcement From Child Protective Services

This notification is being made due to a report of suspected child abuse or neglect that alleges one or more of the following* (check all that apply):

<input type="checkbox"/>	Death of a child
<input type="checkbox"/>	A felony or Class 1 misdemeanor injury or threatened injury to a child
<input type="checkbox"/>	Sexual abuse, suspected sexual abuse or other sexual offense involving a child, including but not limited to the use or display of a child in sexually explicit visual material, as defined in § 18.2-374.1
<input type="checkbox"/>	Abduction of a child
<input type="checkbox"/>	Felony or Class 1 misdemeanor drug offense involving a child
<input type="checkbox"/>	Contributing to the delinquency of a minor in violation of § 18.2-371

* Refer to Section 3.6 of the CPS Policy/ Guidance Manual for additional information

Name (s) of victim children involved		Name (s) of alleged perpetrators (if known)	
		Initial Notification to law enforcement	
OASIS Referral #	Date:	Time:	
Name of LDSS representative	Date	Time	Signature (may be electronic)
Name of local law enforcement officer	Date	Time	Signature (may be electronic)
<small>This form documents notification to local law enforcement pursuant to § 63.2-1503 of the Code of Virginia. This document shall be completed and signed by all parties within two business days of receipt of CPS report. A copy of this form shall be included in the CPS record. This form may be completed in writing or electronically.</small>			

3.13 Appendix D: CPS Intake Tool

OASIS Case Name: _____ Referral #: _____ FIPS Code: _____

Worker Name: _____ Supervisor: _____ Referral Date: ____/____/____

STEP 1: SCREENING ASSESSMENT

Section 1: Maltreatment Type

Neglect occurs when a parent or other person responsible for child's care neglects or refuses to provide care necessary for child's health; when a child is without parental care or guardianship caused by the unreasonable absence or the mental or physical incapacity of the child's parent, guardian, legal custodian, or other person standing in loco parentis; when parent(s) or other person(s) responsible for child's care abandons such child.

_____ Abandonment: Child is deserted by parent/caretaker, and there are no apparent plans to return.

_____ Inadequate Supervision:

_____ Incapacitated Caretaker (includes physical and/or mental incapacitation, use of substances)

_____ Child has been left in the care of an inadequate caretaker or in a situation requiring judgment or actions greater than the child's level of maturity, physical condition, and/or mental abilities would reasonably dictate.

_____ Parent/caretaker ignored/disregarded pertinent information about either the child's behavior history or self-management abilities.

_____ Parent/caretaker locks child in or out, or expels a child from the home.

_____ Parent/caretaker fails to protect child from abuse/neglect and/or allows continued access to child by someone who the parent/caretaker knows has previously maltreated the child.

_____ Parent/caretaker leaves the child alone in the same dwelling with a person not related by blood or marriage who has been convicted of an offense against a minor for which registration is required as a violent sexual offender pursuant to [§ 9.1-902](#).

_____ Exploitation (non-sexual): Parent/caretaker uses child to perform illegal acts to benefit the parent/caretaker.

_____ Inadequate Basic Care (clothing, shelter, hygiene, nutrition):

_____ Child's home environment, including lack of heat or shelter and unsanitary household conditions, is hazardous and could lead to injury or illness of the child if not resolved.

_____ Parent/caretaker has failed to meet a child's basic needs for clothing and/or hygiene to the extent that the child's functioning is impaired or there are medical indications such as sores, infection, physical illness, or serious harm such as hypothermia or frostbite.

_____ Child is without food (consider age of child and length of time) or is malnourished as a result of commission or omission by a parent/caretaker.

_____ Inadequate Medical/Mental Health Care:

_____ Parent/caretaker is failing to seek, obtain, or follow through with medical attention for a specific moderate-to-serious medical or dental injury, illness, or condition for a child, including failure to use prescribed drugs (consider medication, medical condition, adverse effect, injury to self or other). Include emergency treatment, necessary care or treatment, and necessary dental care or treatment.

_____ Parent/caretaker is unwilling to obtain mental health services and intervention for a child in need of treatment or evaluation (includes suicide threats or attempts, severe emotional disorders, exhibiting behaviors dangerous to self or others, etc.).

_____ Non-organic Failure to Thrive Attributed to Physical Neglect

_____ Substance-exposed Infant:

Mental Abuse occurs when a caretaker creates or inflicts, threatens to create or inflict, or allows to be created or inflicted upon a child a mental injury by other than accidental means, or creates a substantial risk of impairment of mental functions.

_____ Emotional or Psychological: An incident or pattern of behavior directed toward a child (e.g., berating, name calling, domestic violence, rejection, etc.) by a parent/caretaker that interferes with that child's normal daily functioning and can be linked to psychological or physical ailments of the child.

_____ Exposure to Domestic Violence that results in demonstrated dysfunction by the child.

_____ Non-organic Failure to Thrive attributed to mental abuse.

Physical Abuse occurs when a caretaker creates or inflicts, threatens to create or inflict, or allows to be created or inflicted upon a child a physical injury by other than accidental means, or creates a substantial risk of death, disfigurement, or impairment of bodily functions.

_____ Non-accidental or Suspicious Injury to a child by a parent/caretaker. Suspicious injuries include injuries that are inconsistent with the parent/caretaker's explanation; multiple inconsistent explanations for injuries; marks that resemble objects such as extension cords, belts, etc.; and/or injuries located in unusual areas of the body such as the inner thigh, ears, torso, etc. Include asphyxiation, bone fracture, brain damage/skull fracture/subdural hematoma, burns / scalding, cuts/bruises/welts/abrasions, internal injuries, sprains / dislocation, gunshot/stab wounds, battered child syndrome, shaken baby syndrome (include injury to child sustained during domestic violence incident).

_____ Old, Healed, or Healing Injuries that have gone untreated and appear suspicious as reported by a medical professional. Include any of the above that are not new injuries.

_____ Inappropriate Giving of Drugs to a child by a parent/caretaker, including use of illicit drugs by a breastfeeding parent that is reported by a medical professional as having adverse effects on the child. Include poisoning.

_____ Munchausen's Syndrome by Proxy or suspicion of it is reported by a medical or mental health professional who provides documentation supporting the allegation.

_____ Parent/Caretaker Action(s) Indicates Excessive Force or Threat of Force That Would Reasonably Cause Injury to a child where injuries may not have occurred or be visible, such as hitting with a fist, choking, etc. Include bizarre discipline.

_____ Exposure to Drug-related Activity: Allowing child to be present during the sale or manufacture of drugs.

_____ Verbal Threat of Serious/Life-threatening Physical Harm Toward a Child by a parent/caretaker, as evidenced by gestures/statements made by the parent/caretaker or the parent/caretaker's behavior, such as stating a fear of harming/killing the child, holding a gun to a child's head, use of a weapon, etc. Evidence of injuries need not be present.

Sexual Abuse occurs when parent(s) or other person(s) responsible for child's care commits or allows to be committed any act of sexual exploitation or any sexual act upon a child in violation of the law.

- _____ Sexual Contact or Exploitation involving a child (under age 18) by a parent/caretaker. This includes reports of sibling/adolescent sexual contact where a caretaker role exists or consensual sex involving a child with a person who has care, custody, and control.

- _____ Disclosure by a Child of an incident of sexual abuse by someone who had care, custody, and control at the time of the alleged incident, whether or not a specific offender is identified.

- _____ Physical, Behavioral, or Suspicious Indicators Consistent With Sexual Abuse reported by a mandated reporter, even without disclosure.

Section 2: Screening Decision

Validated as CA/N: _____ Yes (Complete Step 2, Response Priority)

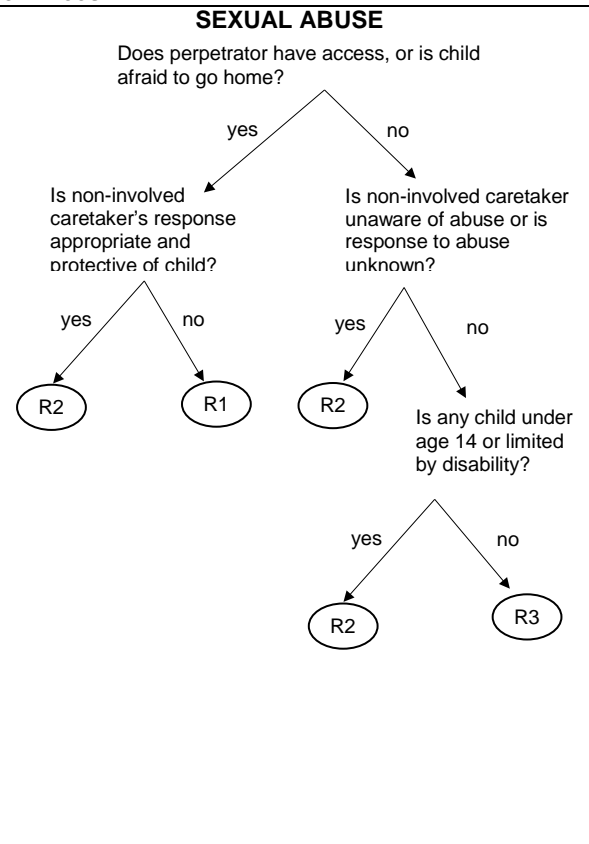
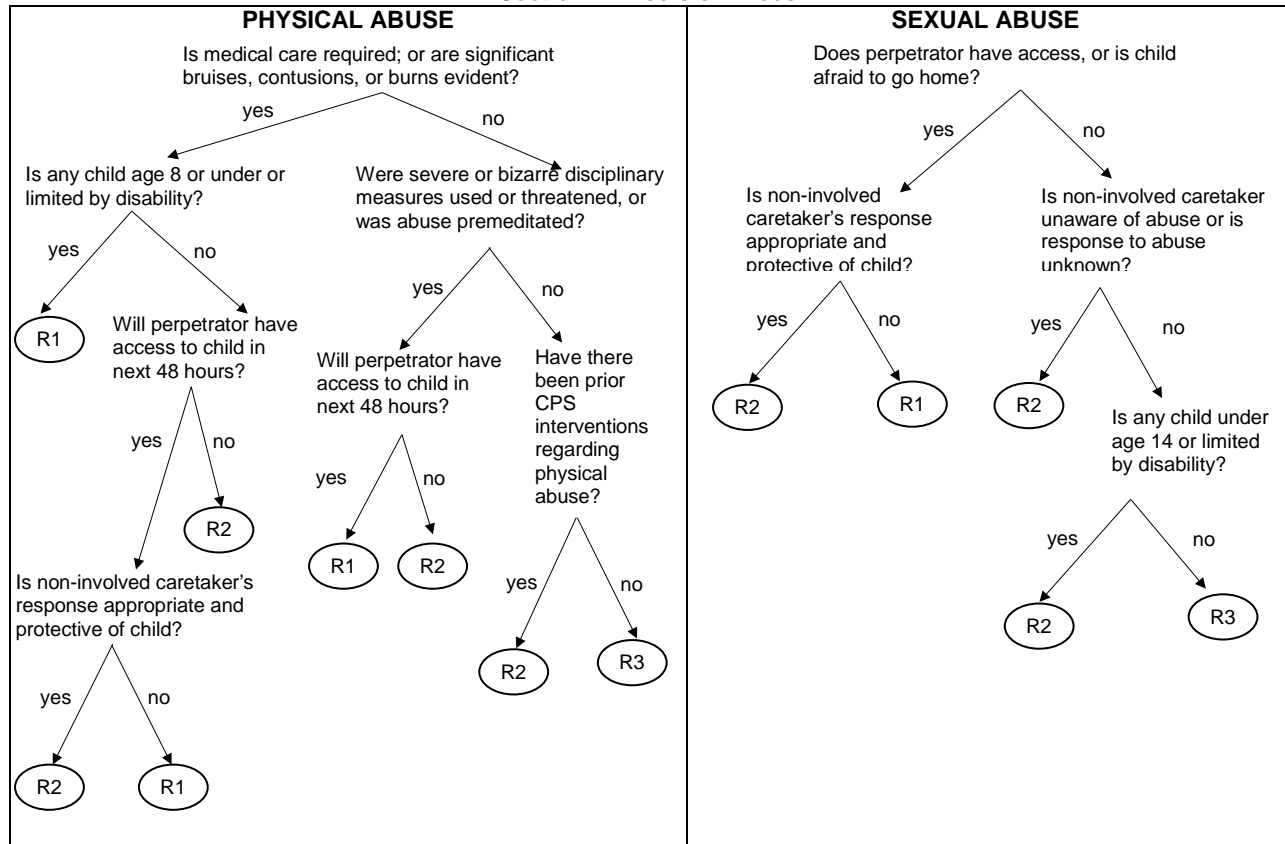
_____ No (Check all alternative actions. Do not complete Response Priority):

- | | |
|--|---|
| _____ Message/Retain Invalid Report | _____ Information Passed on to Case Manager |
| _____ External Preventive Service Referral | _____ Law Enforcement |
| _____ Internal Preventive Service Referral | _____ Other: _____ |
| _____ Judicial Referral | |

Additional Information:

STEP 2: RESPONSE PRIORITY

Section 1: Decision Trees



Section 2: Overrides

Policy Override:

Shall increase to R1 whenever:

- a. Family is about to flee or has a history of fleeing;
- b. Forensic investigation would be compromised if investigation/assessment is delayed;
- c. Law enforcement is requesting immediate response; or
- d. Allegation is exposure to drug-related activity and involves a meth lab.

May decrease by one priority level whenever:

- a. Child is in alternate safe environment; or
- b. A substantial period of time has passed since the incident occurred.

Discretionary Override (requires supervisor approval):

- Increase one level; or
- Decrease one level.

Reason: _____

FINAL ASSIGNED RESPONSE TIME

R1 = as soon as possible within 24 hours

R2 = as soon as possible within 48 hours

R3 = as soon as possible within five working days

STEP 3: DIFFERENTIAL RESPONSE DECISION

Mark either investigation or assessment, and check all applicable reasons within column.

INVESTIGATION

Mandatory investigation reasons (if one or more apply, MUST be assigned as investigation):

- Sexual abuse
- Child fatality
- Serious injury per §18.2-371.1
- Child taken into custody due to child abuse/neglect (CA/N)
- Child taken into custody by physician or law enforcement
- Out-of-family (OOF; no further SDM completed)
- Baby Doe
- Third report within 12 months

Suggested investigation reasons:

Physical Abuse

- Injury is serious, but less serious than §18.2-371.1
- Injury requires medical evaluation, treatment, or hospitalization
- Exposure to sale or manufacture of certain drugs

Mental Abuse

- Serious distress or impairment of child
- Emotional needs not met or severely threatened

Neglect

- Serious injury or illness due to lack of supervision
- Injury or threat of injury due to weapons in home
- Non-organic failure to thrive of infant at imminent risk of severe harm
- Abandonment

Other: _____

FAMILY ASSESSMENT

- No mandatory investigation circumstances are present (must be checked if family assessment is selected)

Suggested assessment reasons:

Physical Abuse

- No injury, or injury that does not require medical treatment

Mental Abuse

- Minor distress or impairment
- Emotional needs sporadically met and behavioral indicators of impact

_____ Exposed to domestic violence but no immediate threat of harm

Neglect

_____ Lack of supervision but child not in danger at time of report

_____ Inattention to safety results in no or minor injuries

_____ Substance-exposed infant

Other: _____

3.13.1 Screening assessment definitions

If one or more maltreatment types are selected in Section 1 and other validation requirements are met (child is under age 18, alleged abuser is caretaker, and jurisdiction exists), mark “yes” (validated as CA/N) in Section 2 and proceed directly to Step 2, Response Priority. **DO NOT SELECT ANY OF THE FOLLOWING IF REFERRAL WILL BE SCREENED IN.**

If no maltreatment types are selected in Section 1, mark “no” in Section 2. There will not be an investigation or assessment. There may be alternative actions taken or recommended. If so, check all of the following alternative actions that apply.

Message/Retain Invalid Report. The given information does not meet validity requirements and no other referrals were given to the caller. However, information about the call will be maintained in OASIS.

External Preventive Service Referral. The caller was referred to an agency in the community, such as child support enforcement, private counseling, mediation services, etc.

Internal Preventive Service Referral. The caller was referred to an existing service program within the agency **OTHER THAN FOR A CA/N INVESTIGATION OR ASSESSMENT.** Examples may include family preservation, homeless prevention, daycare, etc.

Judicial Referral. The caller was referred to the juvenile courts for assistance with visitation, custody matters, CHINS petitions, etc.

Information Passed on to Case Manager. Caller is providing information on an open case that does not constitute a new referral.

Law Enforcement. The caller was referred to law enforcement and/or the referral information will be relayed to law enforcement by the worker per policy, but there will be no CA/N investigation or assessment in conjunction with law enforcement response.

3.13.2 Response priority definitions

PHYSICAL ABUSE

Is medical care required; or are significant bruises, contusions, or burns evident?

- Medical care includes any intervention performed by a health care professional to treat an injury. (Do not include forensic medical evaluations)

solely done for the purpose of documenting injury, or evaluation to determine IF there is an injury.)

- Include significant bruises, contusions, or burns that did not require medical care. Significance is gauged by considering location (e.g., injuries to soft tissue, face, abdomen, or buttocks are considered more significant than injuries over bony prominences such as elbows, knees, shins); scope (e.g., injuries over multiple body surfaces or covering larger areas are considered more significant than a small, isolated bruise); and recency of injury (e.g., new injuries are considered more significant than old scars). A pattern of injuries apparently inflicted over a period of time should be considered significant.

Is any child age eight (8) or under or limited by disability?

If the injured child has not reached his/her ninth birthday, or is as vulnerable as a child eight (8) or under due to known cognitive or physical disability, answer yes. All others, answer no.

Will perpetrator have access to child in next 48 hours?

If perpetrator is identified, is it likely that perpetrator will be in physical proximity of the child within 48 hours? Also include verbal/written or third-party access if the perpetrator has used such indirect contact in an attempt to influence the child's statements or threaten the child in any way.

If the perpetrator is unknown, access must be assumed. Answer yes.

Is non-involved caretaker's response appropriate and protective of child?

A non-involved caretaker is one who did not directly participate in the alleged maltreatment of the child. An appropriate and protective response may be characterized by acknowledgment that the perpetrator's actions were inappropriate; awareness of and concern for the impact of maltreatment on the child; and acceptance of the child's report of abuse. A protective response may be evidenced by setting limits on the alleged perpetrator's contact with the child, involvement with discipline, etc. Consider the emotional and physical ability of the non-perpetrating caretaker to carry out intended protective measures.

Were severe or bizarre disciplinary measures used or threatened, or was abuse premeditated?

- Did perpetrator act in ways that presented high potential for serious harm (e.g., throwing a heavy object toward child's head, punching in abdomen)? Did perpetrator act in ways that suggest extremely distorted and dangerous

concepts of child discipline (e.g., locking in cage, surpassing child's physical or emotional capacity to endure, exposing to severe elements)?

OR

- Is there evidence that perpetrator planned in advance to physically harm child? Answer no if caretaker planned in advance to take the action but did not intend the action to cause physical injury.

Will perpetrator have access to child in next 48 hours?

If perpetrator is identified, is it likely that perpetrator will be in physical proximity of the child within 48 hours? Also include verbal/written or third-party access if there is reason to believe the perpetrator will attempt to influence the child's statements or threaten the child in any way.

If the perpetrator is unknown, access must be assumed. Answer yes.

Have there regarding physical been prior CPS interventions abuse?

Include any prior investigation/assessment for physical abuse that was founded or where services were indicated (investigations/assessments determined to be unfounded are excluded).

SEXUAL ABUSE

Does perpetrator have access, or is child afraid to go home?

- If perpetrator is identified, is it likely that the perpetrator will be in physical proximity of the child within 48 hours? Also include verbal/written or third-party access if the perpetrator has used such indirect contact to influence the child's statements or threaten the child in any way. If the perpetrator is not identified, also answer yes.
- Does child express fear (verbally or nonverbally) of remaining at or returning home?

Is non-involved caretaker's response appropriate and protective of child?

A non-involved caretaker is one who did not directly participate in the alleged maltreatment of the child. An appropriate and protective response may be characterized by acknowledgment that the perpetrator's actions were inappropriate; awareness of and concern for the impact of maltreatment on the child; and acceptance of the child's report of abuse. A protective response may be evidenced by obtaining medical evaluation, if indicated, and discontinuing contact between

alleged perpetrator and child. Consider the emotional and physical ability of the non-perpetrating caretaker to carry out intended protective measures. Any attempt by the caretaker to influence the child's statement one way or the other is considered an inappropriate response.

Is non-involved caretaker unaware of abuse or is response to abuse unknown?

Answer yes if:

- Report is from a third party and the non-involved caretaker has not yet been informed of the allegation.
- The non-involved caretaker may have learned of the alleged abuse but the caller has no information concerning the caretaker's reaction.
- Is any child under age 14 or limited by disability?
- If the child has not reached his or her 14th birthday, or is as vulnerable as a child under age 14 due to known cognitive or physical disability, answer yes. All others answer no.

NEGLECT (Includes medical neglect and abandonment)

Is the living situation immediately dangerous; is any child currently left unsupervised who is age 8 or under or too disabled to care for self; does child appear seriously ill or injured and in need of immediate medical care; is caretaker not available and no provision for care has been made; or is the child currently alone with, or repeatedly left alone with, a non-related violent sex offender?

Answer yes if the following:

- Based on the child's age and developmental status, the child's physical living conditions are hazardous and immediately threatening. Examples include but are not limited to the following:
 - Exposure to animals known to be a danger.
 - Unsafe heating or cooking equipment.
 - Substances or objects accessible to the child that may endanger the health and/or safety of the child.
 - Lack of water or utilities (heat, plumbing, electricity) and no alternate or safe provisions are made.

- Exposed electrical wires.
- Excessive garbage or rotted or spoiled food that threatens health.
- Serious illness or significant injury has occurred due to living conditions and these conditions still exist (e.g., lead poisoning, rat bites).
- Evidence of human or animal waste throughout living quarters.
- Guns and other weapons are accessible to child.
- Complete or near-complete absence of food.

OR

- Child is age 8 or under or is as vulnerable as a child age 8 or under due to known cognitive or physical disability AND:
 - Child is currently alone or is scheduled to be alone within the next 48 hours.
 - Caretaker does not attend to child to the extent that need for care goes unnoticed or unmet (e.g., caretaker is present but child can play with dangerous objects or be exposed to other serious hazards).
 - Child is being supervised by an alternate caretaker who is unable to meet child's immediate needs for care and supervision.

OR

- Child's unmet medical need may result in serious harm, serious aggravation of symptoms, increased risk of long-term or permanent injury or impairment, or death if not treated **within 48 hours**. Examples include but are not limited to the following:
 - Apparent bone injury that has not been set;
 - Apparent second- or third-degree burn that has not been medically evaluated.
 - Untreated dehydration.
 - Breathing difficulties.
 - Severe abdominal pain.
 - Loss of consciousness or altered mental status.

- Failure to thrive.
- Untreated exposure to the elements; frostbite.

OR

Caretaker:

- Left the child without affording means of identifying the child and the child's parent or guardian.
- Is absent from the home for a period of time that creates a substantial risk of serious harm to a child left in the home.
- Left the child with another person without provision for the child's support and the other person is no longer able or willing to provide care.
- Caretaker has currently left, or repeatedly leaves, the child alone in the same dwelling as a person not related by blood or marriage who has been convicted of an offense against a minor for which registration is required as a violent sexual offender pursuant to [§ 9.1-902](#).

Are severe parental or caretaker substance abuse, developmental disabilities, or mental illness issues present AND no other appropriate caretaker is present?

Answer yes if **caretaker**:

- Is currently impaired by alcohol or other drugs to the extent that he/she is not providing for the child's needs for care and safety, and this has resulted or is likely to result in injury, illness, or harm to the child.
- Is cognitively impaired to the extent that he or she lacks basic understanding of child's needs for care and supervision, and this lack of understanding has resulted or is likely to result in injury, illness, or harm to the child.
- Is mentally ill to the extent that he/she is unable to meet child's needs for care and supervision, and this has resulted or is likely to result in injury illness, or harm to the child. Examples include but are not limited to the following:
 - Loss of touch with reality.
 - Paranoid thoughts, especially those in which child may be seen as evil.
 - Severe depression that interferes with ability to function at even most basic levels.

- Suicidal ideation (includes all direct or indirect threats, attempts, or behavioral indicators of suicidal ideation).
- A substance-exposed newborn represents severe parental substance abuse for the purposes of this question.

AND

- No other adult is present who is able to provide for the child's protection and care.

Is any child age eight (8) or under or limited by disability?

If any child has not reached his/her ninth birthday, or is as vulnerable as a child eight (8) or under due to known cognitive or physical disability, answer yes. All others, answer no.

Have there been prior CPS interventions?

Include any prior investigation/assessment that was founded or where services were indicated (investigations/assessments determined to be unfounded are excluded).

MENTAL ABUSE (Includes exposure to domestic violence)

Is caretaker's behavior toward child extreme, severe, or bizarre; or does child's behavior put self at risk and caretaker does not respond appropriately?

Examples of extreme, severe, or bizarre behavior include the following:

- Caretaker threatens to harm self in child's presence.
- Unusual forms of discipline (e.g., child standing in corner on one leg; forcing child to wear inappropriate clothing, such as a 10-year-old being forced to wear diapers—this should NOT include incidents of inappropriate clothing due to poverty or current fashion).
- Murder or torture of people or pets in front of child.
- Child's extreme rejection from family (e.g., abnormally long time-outs based on child's age and developmental level; family acts as if child does not exist).
- Child singled out for detrimental treatment.
- Caretaker is constantly belittling child or has unrealistic expectations of child.

OR

- Child is suicidal, self-mutilating, or engaging in other behavior that has caused or is likely to cause serious physical injury or death, AND caretaker is unable or unwilling to provide monitoring, support, mental health services, or hospitalization necessary to protect child.

Does information show observable and substantial impairment in child's ability to function in a developmentally appropriate manner?

Examples include chronic somatic complaints; enuresis/encopresis not due to medical condition; long-term withdrawal/depression/isolation from family or school activities; severe aggressive behavior; cruelty toward animals; fire setting.

Is any child age eight (8) or under or limited by disability?

If any child has not reached his/her ninth birthday, or is as vulnerable as a child eight (8) or under due to known cognitive or physical disability, answer yes. All others, answer no.

OVERRIDES

Policy Overrides

Shall increase to R1 whenever:

- **Family is about to flee or has a history of fleeing.** Family is preparing to leave the jurisdiction to avoid investigation/assessment, or has fled in the past.
- **Forensic investigation would be compromised if investigation/assessment is delayed.** Physical evidence may be lost or altered; attempts are being made to alter statements, conceal evidence, or coordinate false statements.
- **Law enforcement is requesting immediate response.**
- **Allegation is exposure to drug-related activity and involves a meth lab.**

May decrease by one priority level whenever:

- **Child is in alternate safe environment.** Child is no longer living where alleged abuse/neglect occurred, or is temporarily away and will not return for 48 hours if overriding to R2 or five working days if overriding to R3.
- **A substantial period of time has passed since the incident occurred.** The incident happened long ago and there is reason to believe no additional incidents have occurred since then.

3.13.3 CPS intake tool procedures

The intake tool assists workers with two (2) decisions:

- The purpose of the screening assessment (Step 1) is to assess whether calls meet the definitional criteria for a child A/N investigation/assessment.
- The response priority decision trees (Step 2) are designed to assist in determining how quickly to initiate the first meaningful contact for assigned investigations/assessments. By answering a series of questions, the trees aid in determining the priority level for responding to a case. Each priority level includes a suggested timeframe for response.

Response 1 (R1) = as soon as possible within 24 hours

Response 2 (R2) = as soon as possible within 48 hours

Response 3 (R3) = as soon as possible within five (5) working days

Which Cases: The screening assessment (Step 1) is completed for all calls alleging child A/N. This includes telephone and all other means of report, and includes new reports of child A/N on open cases.

The response priority (Step 2) is completed for all valid reports of child A/N.

Who: The local intake worker.

When: As soon as possible upon receipt of the report.

Decisions: The screening assessment (Step 1) assists the worker in determining whether a report meets child A/N investigation / assessment definitions.

The response priority (Step 2) assists workers in determining when they must initiate the first meaningful contact. R1 reports require that the first meaningful contact occurs **as soon as possible within 24 hours**; R2 reports require that the first meaningful contact occurs **within 48 hours**; and R3 reports require that the first meaningful contact occurs **within five working days**. The timelines referenced in the decision trees commence at the time the report is made.

Appropriate Completion:

Step 1: Screening Assessment

In Section 1, mark the specific criteria for all allegations indicated in the report under the appropriate maltreatment category.

In Section 2, indicate whether the report is being validated as a child A/N report by checking either “yes” or “no.” If any of the maltreatment criteria were checked and the other validity criteria are met (child under age 18, alleged perpetrator is a caretaker, and jurisdiction exists), the report should be validated as child A/N. Reports that do not meet any of the screen-in criteria should not be validated as child A/N reports.

For reports that are not validated as a child A/N report, indicate with a check mark if the referral meets criteria for some alternative action (e.g., external preventive service referral).

For “duplicate referrals” (an allegation is reported, accepted, and assigned for an investigation/assessment one day, and then a few days later, a different caller makes the same allegation on the same family, based on the same set of issues - it is the same thing reported twice) in OASIS, treat the duplicate referral as “Invalid – Duplicate Referral.” On the SDM intake tool: 1) in Section 1, check none of the allegation sub-types; 2) in Section 2, check “No” (not validated as child A/N); and 3) in Section 2, under “Other Information,” type in “Duplicate Referral” and if available, give the referral number for the original validated referral. Do not complete the response priority or differential response sections of the intake tool.

Step 2: Response Priority

Information gathered by agency staff must be analyzed to assess the urgency for response. The response priority decision trees structure this analysis to determine a response priority level. The decision trees ask a series of questions depending on the type of alleged maltreatment (physical abuse, sexual abuse, neglect, and mental abuse). Answers to each question, consisting of “yes” or “no” responses, will lead to another question, and ultimately, a response priority level.

If more than one type of maltreatment is alleged, complete all applicable decision trees to determine the most urgent response priority level. Once a response of R1 has been obtained, it is not necessary to complete additional trees.

Overrides: After reviewing all necessary decision trees, consider whether or not an override should be applied.

A policy override to R1 shall be applied whenever:

- Family is about to flee or has a history of fleeing;
- Forensic investigation would be compromised if investigation/ assessment is delayed;
- Law enforcement is requesting immediate response;

- Allegation is exposure to drug-related activity and involves a meth lab.

A policy override may be used to decrease response by one level whenever:

- Child is in an alternate safe environment;
- A substantial period of time has passed since the incident occurred.

A discretionary override may be applied if, after completion of all necessary decision trees and application of policy overrides, worker and supervisor determine that there are unique conditions not captured by the tool that warrant a different response priority. A discretionary override may increase or decrease the response time by one level.

Step 3: Differential Response Decision

The final step in assigning a valid referral is to determine whether the referral will be assigned as an investigation or an assessment. These decisions are currently guided by state statute and local policy. The worker will check whether the referral is assigned as an investigation or as a family assessment, and check all applicable reasons for this decision. If assigned as an assessment, “No mandatory investigation circumstances are present” must be checked. NOTE THAT THIS IS NOT A STRUCTURED DECISION AT THIS TIME.