CHEROKEE COUNTY CHILD ABUSE PROTOCOL

Revised March 2025

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1. INTRODUCTION

a. What is a Child Abuse Protocol?

This Child Abuse Protocol (CAP) is established for Cherokee County, consistent with O.C.G.A. § 19-15-2, for the investigation and prosecution of alleged cases of child abuse. The CAP is a comprehensive guide to the handling of all child abuse cases, including physical abuse, neglect, sexual abuse, and sexual exploitation. This protocol applies to all children under the age of 18. This protocol outlines in detail the procedures to be used in investigating and prosecuting cases arising from alleged child abuse, including violence between household members, and the methods to be used in coordinating treatment programs for the perpetrator, the family, and the child.

b. Purpose

The purpose of the protocol is to ensure coordination and cooperation between all agencies involved in child abuse cases, to:

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

2. THE PROTOCOL COMMITTEE

a. Membership

The chairperson of the Cherokee County Child Abuse Protocol Committee ("the Committee") is the District Attorney and her designees. The chairperson is responsible for ensuring that the protocol procedures are being followed by all agencies and the protocol is updated and revised as needed.

Each of the following agencies shall designate a representative from their respective offices to be a member and to serve on the Committee in accordance with O.C.G.A. § 19-15-2. Preferably, the representative will be one who is involved in child abuse and exploitation cases.

The following agencies are mandated by statute to participate on the Committee:

a) The sheriff;
b) The county department of family and children's services;
c) The district attorney for the judicial circuit;
d) The juvenile court judge;
e) The chief magistrate;
f) The county board of education;
g) The county mental health organization;
h) The chief of police of a county in counties which have a county police department;
i) The chief of police of the largest municipality in the county;
j) The county public health department, which shall designate a physician to serve on the protocol committee; and
k) The coroner or county medical examiner.

Also required to serve on the committee is a representative of a local child advocacy center, a representative of sexual assault center, and a representative from a local citizen or advocacy group focused on child abuse awareness and prevention.

Although not legally required, other encouraged members include medical providers with child maltreatment expertise, court appointed special advocates (CASA), city police departments located within the county, and Commercial Sexual Exploitation of Children MDT members and response teams.

b. Mission

1) To write, review and establish the protocol document;
2) To coordinate the efforts of all agencies that investigate, review, treat, and manage child abuse and neglect cases, and

3) To facilitate and support agencies, organizations, and individuals involved in child abuse prevention.

c. Responsibilities of the Committee

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

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

See Appendix A for O.C.G.A. § 19-15-2, the statute governing the Child Abuse Protocol Committee.

d. Conflict Resolution

If any agency experiences an issue with the operation of the protocol, that member needs to initiate contact with any other agencies involved and work to resolve the matter. When determining the appropriate course of action, the Committee shall bear in mind that the purpose of the protocol is to foster communication and cooperation amongst agencies. The resolution of the matter should be forwarded to the Chair for tracking purposes and consideration of necessary revisions to the protocol.

If a CAP member is routinely absent, the Chair will contact the member directly and notify the member of their responsibility to attend the meetings. If the issue persists, a follow-up letter will be sent to the supervisor within the agency. If necessary, the Chair will follow the chain of command within the agency and will document efforts to obtain compliance. Finally, the Chair will involve the designated superior court judge and will consider filing a motion for contempt as authorized under O.C.G.A. § 19-5-3(3).

No protocol can purport to offer a comprehensive set of guidelines to the infinite number of circumstances faced by human service providers. When faced with situations not covered by this protocol, agencies are urged to use the protocol in conjunction with agency supervision and sound judgment to provide safety and welfare for the children of Cherokee County.

e. Meetings, Access to Records and Confidentiality

The Committee shall have reasonable access to records concerning reports of child abuse pursuant to O.C.G.A. § 49-5-41. Information and records acquired by the Committee shall be confidential, shall not be disclosed, and shall not be subject to the Open Records Act, or subject to subpoena, discovery, or introduction into evidence in any civil or criminal proceeding.

Committee meetings in the exercise of its duties shall be closed to the public and shall not be subject to Chapter 14 of Title 50, relating to open meetings. Members shall not disclose what transpires at meetings nor disclose any information obtained during the meeting.

A person who presents information to a protocol committee or who is a member of any such body shall not be questioned in any civil or criminal proceeding regarding such presentation or regarding opinions formed by or confidential information obtained by such person as a result of serving as a member of any such body. Members may still testify regarding information about the case so long as the information was obtained independently of the protocol committee. O.C.G.A. § 19-15-6.

Records and other documents which are made public records by other law(s) shall remain public records notwithstanding their being obtained, considered, or both, by a protocol committee. Additionally, notwithstanding any other provisions of law, information acquired by and documents, records, and reports of the child abuse protocol committees *applicable to a child who at the time of his or her death* was in the custody of a state department or agency or foster parent shall <u>not</u> be confidential and shall be subject to Article 4 of Chapter 18 of Title 50, relating to open records.

A member of a protocol committee shall not be civilly or criminally liable for any disclosure of information made by such member as authorized by law. See O.C.G.A. §§ 19-15-5(a), 19-15-6, 49-5-41(a)(9), and 49-5-41(c)(5).

3. COLLABORATIVE RESPONSE TO CHILD ABUSE

a. Roles of Agencies

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

1) Mandated reports, including education personnel and medical personnel among others, are primarily responsible for identifying and reporting suspected child abuse.
2) Law enforcement is primarily responsible for investigating to determine whether a crime has been committed, identifying and apprehending the offender(s), and filing the appropriate criminal charges.
3) DFCS is primarily responsible for responding to reports of abuse to determine if maltreatment occurred; assessing safety and risk; ensuring the safety of the alleged victim and any other children in the home; and ensuring the family has access to appropriate services.
4) Child advocacy centers (CACs) are primarily responsible for conducting forensic interviews to inform the investigations conducted by law enforcement and DFCS.
5) Medical personnel, mental health organizations and counselors, child advocacy centers and sexual assault centers provide exams, diagnoses, and treatment.
6) Coroners and medical examiners evaluate and determine a person's manner and cause of death. Their findings may inform the criminal and civil response to cases involving child abuse.
7) Superior courts maintain jurisdiction for felony criminal matters related to child abuse. State courts handle misdemeanor criminal cases, including domestic violence cases. Magistrate courts are primarily involved in child abuse cases through the issuance of criminal warrants against perpetrators, the holding of probable cause hearings and setting bond conditions. The District Attorney's and Solicitor-General's offices are responsible for prosecuting criminal actions of child abuse.
8) Juvenile courts maintain jurisdiction for dependency matters related to child abuse.

b. Multi-Disciplinary Response

A coordinated, multi-disciplinary response is a critical and vital component to the investigation and prosecution of child abuse cases and involves consistent communication; cross-reporting of allegations; joint investigations and collaborative interviewing; and multi-disciplinary case reviews. The goals of a coordinated response are to ensure an appropriate response to concerns of child abuse; minimize the number of interviews a child undergoes; ensure

sensitive treatment of the child victim and their family; preserve the integrity of an investigation that may lead to court involvement; enhance the quality of evidence discovered for civil litigation or criminal prosecution while eliminating duplication of efforts; and provide information essential to family treatment agencies. Early cooperation minimizes the likelihood of conflicts different philosophies among agencies and encourages consistent reporting practices.

As such, law enforcement, DFCS and participating disciplines should educate each other on their respective roles, abilities, and limitations when responding to child abuse cases such that all partners understand the dynamics of victimization, child development, and the civil and criminal justice process as it relates to children.

4. REPORTING CHILD ABUSE

a. Child Abuse Defined

Pursuant to O.C.G.A. § 19-7-5, child abuse is defined as:

- Physical injury or death inflicted upon a child by a parent, guardian, legal custodian or other person responsible for the care of such child by other than accidental means, excluding reasonable forms of physical discipline as long as there is no physical injury to the child.
- Neglect of a child by a parent, guardian, legal custodian, or other person responsible for the care of such child
  - The failure to provide proper parental care or control, subsistence, education as required by law, or other care or control necessary for a child's physical, mental, or emotional health or morals;
  - The failure to provide a child with adequate supervision necessary for such child's well-being, or
  - The abandonment of a child by his or her parent, guardian, or legal custodian.
- Emotional abuse
  - "Emotional abuse" means acts or omissions by a parent, guardian, legal custodian, or other person responsible for the care of a child that cause any mental injury to such child's intellectual or psychological capacity as evidenced by observable and significant impairment in such child's ability to function within a child's normal range of performance and behavior or that create a substantial risk of impairment.
- Sexual abuse or sexual exploitation of a child
  - "Sexual abuse" means a person's employing, using, persuading, inducing, enticing, or coercing any minor who is not that person's spouse to engage in any act which involves:
    - Sexual intercourse, including genital-genital, oral-genital, anal-genital, or oral-anal, whether between persons of the same or opposite sex
    - Bestiality
    - Masturbation
    - Lewd exhibition of the genitals or pubic area of any person
    - Flagellation or torture by or upon a person who is nude
    - Condition of being fettered, bound, or otherwise physically restrained on the part of a person who is nude
    - Physical contact in an act of apparent sexual stimulation or gratification with any person's clothed or unclothed genitals, pubic area, or buttocks or with a female's clothed or unclothed breasts
    - Defecation or urination for the purpose of sexual stimulation
    - Penetration of the vagina or rectum by any object except when done as part of a recognized medical procedure, or
    - Trafficking of persons for sexual servitude
  - "Sexual exploitation" means conduct by any person who allows, permits, encourages, or requires a child to engage in:
    - Sexual servitude, as defined in O.C.G.A. § 16-5-46; or
    - Sexually explicit conduct for the purpose of producing any visual or print medium depicting such conduct, as defined in O.C.G.A. § 16-12-100.
- Prenatal abuse of a child by a parent
  - "Prenatal abuse" means exposure to chronic or severe use of alcohol or the unlawful use of any controlled substance, as such term is defined in O.C.G.A. § 16-13-21, which results in:

        - Symptoms of withdrawal in a newborn or the presence of a controlled substance or a metabolite thereof in a newborn's body, blood, urine, or meconium that is not the result of medical treatment; or
        - Medically diagnosed and harmful effects in a newborn's physical appearance or functioning.
- An act or failure to act that presents an imminent risk of serious harm to the child's physical, mental, or emotional health; or
- Trafficking of a child for labor servitude.

Reports of child abuse may come from mandated reporters or non-mandated reporters. Any person who has reasonable cause to believe that a child is abused may report or cause reports to be made. O.C.G.A. § 19-7-5(d).

b. Mandated Reporters

Mandated reporters are required by Georgia law to make a report to DFCS immediately, but in no case, later than 24 hours from the time there is reasonable cause to believe the suspected child abuse has occurred. O.C.G.A. § 19-7-5(c)(1).

The purpose of the mandated reporter law is to provide for the protection of children. Mandatory reporting will trigger the response of state protective services to prevent abuses, protect and enhance the welfare of children, and preserve family life wherever possible. This law shall be liberally construed to carry out these purposes.

Some mandated reporters may have the requirement to notify a designated person within their agency who will have the responsibility to notify DFCS of the report on that person's behalf.

Under no circumstances, shall the designated person, to whom such notification has been made, exercise any control, restraint, modification, or make other change to the information provided by the report. The reporter may be consulted prior to making the report to provide any additional, relevant, or necessary information.

Mandated reporters *will not conduct their own interview* but will gather only sufficient information to determine if a report is necessary.

Mandated Reporters Include:

- Physicians, licensed to practice medicine, physician assistants, interns, or residents
- Hospital or medical personnel
- Dentists
- Licensed psychologists & interns
- Podiatrists
- Registered professional nurses or licensed practical nurses
- Licensed professional counselors, social workers, or marriage and family therapists
- School teachers, including daycare providers
    - School is defined as any public or private pre-kindergarten, elementary school, secondary school, technical school, vocational school, college, university, or institution of postsecondary education
- School administrators
- School guidance counselors, visiting teachers, school social workers, or school psychologists
- Child welfare agency personnel
- Child serving organization personnel (employees and volunteers)
- Law enforcement personnel
- Reproductive health care facility or pregnancy resource center personnel and volunteers

A report must be made to DFCS, law enforcement, or the district attorney. Failure to report suspected abuse is a misdemeanor.

Persons reporting suspected abuse in good faith are immune from civil liability.

c. Procedure for Reporting Abuse

An oral report by telephone or other oral communication or a written report by electronic submission or facsimile shall be made *immediately, but in no case later than 24 hours* from the time there is reasonable cause to believe that suspected child abuse has occurred. O.C.G.A. §19-7-5(e).

If a report of child abuse is made to the agency or independently discovered by the agency, and the agency has reasonable cause to believe such report is true or the report contains any allegation or evidence of child abuse, then the agency shall immediately notify the appropriate police authority or district attorney.

Reports of child abuse occurring in Cherokee County shall be sent to the Cherokee County Department of Family and Children's Services (DFCS) in one of the following ways:

1) Oral report by phone to 1-855-GACHILD/1-855-422-4453 (24 hours a day/7 days a week)
2) A written report by electronic submission to cpsintake@dhs.ga.gov
3) Fax of written report to 229-317-9663
4) Online report by way of the mandated reporter portal (cps.dhs.ga.gov)

Where immediate response is needed, to include child death and serious injuries, contact:

Brooke Ford - Director - 404 576 5107
Taylor Smithey - Program Director - 706 671 0464
Hailey Gagner - CPS Administrator - 470 859 7746

**If unable to reach, call intake and select the option for first responder/law enforcement to speak to on-call supervisor.

For reporting Commercial Sexual Exploitation of Children (CSEC), see pages 26-28.

d. Response to Reports of Child Abuse

i. Cherokee County Department of Family and Children's Services (DFCS)
1300 Univeter Road, Suite 100, Canton, GA 30115

1. Reports are assigned a response time of immediate, 24 hours, or 5 business days. The seriousness of the allegations in the report and the urgency of the safety needs of the child determine response times.
2. If at any time the DFCS investigator discovers the child is in imminent danger of abuse or neglect if he or she remains in the home, there is evidence that a criminal act may have occurred, or there is an allegation of child abuse, the investigator will immediately call the law enforcement agency having jurisdiction and request assistance.
3. Should the DFCS investigator and supervisor determine that the child(ren) must be removed from the home to meet the safety needs of the child, DFCS will seek **protective custody** pursuant to O.C.G.A. § 15-11-133. See Appendix I.
    a. DFCS is permitted to remove children from the home by a court order.
    b. The facts supporting the issue of an order may be relayed orally, including by phone, to the judge or designated juvenile court intake officer.
    c. The order directing a child taken into custody may be issued orally or electronically. O.C.G.A. § 15-11-132.
4. All incidents of child death, serious injury of children, and alleged incidents of abuse or neglect of children in foster care will be referred to the DFCS special investigation unit (as it is formed), worked by county level staff as appropriate, or referred to another county to avoid any appearance of conflict of interest.

ii. Cherokee County Law Enforcement

1. In response to reports of child abuse, law enforcement will:
    a. Initiate an investigation within 24 hours of notification of referral for children who are at imminent risk and within 5 days of notification on all other referrals.
    b. Handle child abuse cases in a priority manner depending on the severity of the abuse being referred.
    c. Be familiar with and make every attempt to adhere to this protocol.
    d. Have at least one officer with advanced training in child abuse investigations to be used as a resource for other officers and to handle more severe cases, if necessary.
    e. Determine jurisdiction and if the allegation of abuse is founded by probable cause.
    f. If a child needs to be interviewed, ensure the interview is conducted by a trained forensic interviewer at the Anna Crawford Children's Center.
    g. File a report with DFCS when a child abuse referral is received from any source other than DFCS.
    h. Notify DFCS immediately if the abuse occurred in the child's home or in a caretaker situation, including instances of child-on-child abuse.

i. Assist and work collaboratively with DFCS in response to child abuse reports, and upon request by DFCS.

2. Law Enforcement Staffing Referrals with DFCS
   a. Law enforcement receives referrals daily from DFCS by email. When disseminating referrals, DFCS will make a reasonable effort to determine jurisdiction of the alleged incident.
   b. Law enforcement will:
      i. Contact DFCS Child Protection Unit weekly to staff referrals when possible.
      ii. Check local files and criminal histories when possible prior to determining disposition of a referral.
      iii. Notify DFCS of records containing a history of child abuse, domestic violence, or physical assault.
      iv. Jointly decide with DFCS on how law enforcement will assist.
      v. Make inquiry of the assigned DFCS investigator of the action to be taken by DFCS.
      vi. Collaborate with DFCS on whether further law enforcement involvement is necessary.

e. Reporting Procedures by Agency

i. Medical Personnel

Medical personnel who believe or become aware of any suspected neglect, physical, or sexual abuse of a child under 18 years of age shall immediately (but in no less than 24 hours) report such abuse or neglect to DFCS or law enforcement. Reports are taken 24 hours a day, 7 days a week by calling 1-855-GACHILD/1-855-422-4453. Such reports should contain the names and addresses of the child and the parent/guardian as found in medical records.

No interviews shall take place prior to a report to DFCS or law enforcement. Questioning should be limited to only enough information necessary to make an appropriate referral.

a. Procedures for Emergency Custody by a Physician

   a. Whenever abuse is suspected, DFCS or law enforcement should be notified; however, under certain circumstances, physicians may be faced with protecting a child who is at risk of "imminent danger."
   b. In order for a physician to take emergency custody of a child, the physician must have reasonable cause to believe that such child:
      i. Is in a circumstance or condition that presents an imminent danger to such child's life or health as a result of suspected abuse or neglect; or
      ii. Has been abused or neglected and there is not sufficient time for a court order to be obtained for temporary custody of such child before such child may be removed from the presence of the physician.

Please refer to Appendix H for an outline regarding medical response to child abuse and the statute regarding the legal requirements for a physician to take emergency custody of a child under O.C.G.A. § 15-11-131.

b. Physician Liability

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

ii. Cherokee County Public Health Department

1219 Univeter Road, Canton, Georgia 30115

1. The staff member shall immediately orally notify DFCS of suspected cases of abuse, pursuant to O.C.G.A. § 19-7-5(e). In no case shall the report be made more than 24 hours from the time staff member has reason to believe the child has been abused.
2. The incident as reported or observed shall be documented in the child's medical record.
3. The child's attending physician shall be notified and advised of the incident.
4. The report to protective services shall contain the following information: child's name, address, age, race, parent's names, care provider, children involved, as appropriate, and nature of the allegation. See Appendix M for optional form to assist in the written reporting process.
5. A copy of the written report shall be maintained in the child's record.
6. The child's right to confidentiality should be respected. Information regarding diagnosis, current condition, and prognosis should be shared only as necessary in response to pertinent questions posed by

protective services personnel. No release of information is required to make this report.

7. The staff member should not verbally disclose to the parents/guardians or legal custodians of the child that a report is being made to protective services until the safety of the child has been established.
8. When a report is made, a therapeutic approach shall always be utilized, presenting protective services as a "help" for families, not a punishment.
9. Reports of suspected abuse and/or neglect made to appropriate protective services or police agencies in good faith render the reporter immune from civil or criminal liability.
10. An incident report should be completed by a public health staff member for each suspected/actual incident of abuse.

iii. Cherokee County School District

1. Introduction

To ensure compliance with Georgia Law, O.C.G.A. § 19-7-5 and the Cherokee County Child Abuse Protocol, the following reporting guidelines will be observed by all Cherokee County School District employees relative to reporting suspected child abuse.

2. What is Reported?

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

3. Reporting Guidelines:

   a. Employee Reporting

Any school district employee or district-allied volunteer having reasonable cause to believe that a child under the age of eighteen years has been abused, neglected or exploited will report their beliefs to the principal/designee of the school that the child attends.

No school district employee or district-allied volunteer will contact a parent/guardian regarding the reporting of their student in child abuse/neglect referrals.

The school district employee is not recognized as a trained interviewer authorized to investigate and interview children on the nature and circumstances of the abuse. Therefore, questioning should be limited to only enough information as necessary to allow the employee to make an appropriate referral. An investigation as to whether abuse has occurred is to be left to protective services of DFCS or the investigators of the police agency involved.

   b. Law Enforcement Involvement

      i. If a law enforcement investigator needs to conduct a minimal facts interview with a child at school concerning child abuse allegations, the investigator should contact Cherokee

County School Police at 770-704-4346 to make arrangements.

ii. During this call, law enforcement investigators should inform Cherokee County School Police that they are investigating child abuse allegations and School Police will dispatch the appropriate Student Resource Officer (SRO).

iii. The SRO will speak directly with the law enforcement investigator and will assist in coordinating contact with the involved student. The SRO will be responsible for informing school administration that they are not to notify the parents/guardians of the interview or investigation.

No employee will restrict, obstruct, or hinder DFCS or law enforcement from investigating child abuse or neglect allegations.

c. Initiating a Referral

The principal/designee will cause a report to be made immediately, but in no case later than 24 hours, to the Department of Family and Children Services (DFCS) by the following options:

1. An oral report by telephone to 1-855-GACHILD/1-855-422-4453 (24 hrs/7 days)
2. A written report, Form JG-4, by electronic submission to cpsintake@dhs.ga.gov
3. Fax of Form JG-4 to 229-317-9663
4. Online report by way of the mandated reporter portal (cps.dhs.ga.gov)

The school reporter will receive confirmation of receipt to the provided email address. The principal/designee will contact CCSD School Police by phone at 770-704-4346 to notify them a referral has been made. They will fax the "Suspected Child Abuse Report Form" to the CCSD School Police department at 770-479-2867.

If additional information is required, the DFCS representative will ask to speak with the reporter. If the reporter is unavailable, the DFCS representative will leave a message requesting an immediate call back so that the referral can progress. If DFCS is unsuccessful in contacting the reporter and receiving a timely call back, they should contact the Office of School Operations for assistance by calling 770-479-1871.

d. Reporting Abuse Occurring in the School Setting:

To ensure compliance with state law and school board policy, the following procedures are designed to address allegations of child abuse occurring in the school setting:

1. The school district will make available the child abuse reporting information/referral forms to students, parents, and the community via the CCSD website, annual CCSD Student/Parent Handbook and school-site postings.
2. In addition to the timely reporting of suspected child abuse, the reporting school's principal will also immediately notify the Office of School Operations at 770-479-1871 and CCSD School Police at 770-704-4346 when an alleged cases of abuse or neglect involves a school district employee (because of the need to introduce the School District's Initial Allegation of Employee Misconduct procedures). Upon the principal's subsequent submission of CCSD's Initial Allegation of Employee Misconduct forms, CCSD School Police will seek authorization from the Superintendent to initiate an investigation/inquiry in accordance with School District protocols.
3. In suspected child abuse cases involving allegations of abuse in the school setting, the principal will also complete the following actions to protect both the alleged victim and the alleged offender during the investigation/inquiry:
    a. Notify the alleged victim's parents/guardians of the allegation and reporting.
    b. Notify the alleged offender/employee of the allegation and reporting; and further instruct that employee to have no discussion with the alleged victim about the report.
    c. Instruct any potential witness to the allegation that their cooperation with the investigation is required.
    d. Work in conjunction with the Office of Personnel Management to determine if the allegations contained with the report warrant removal of the alleged offender from contact with the alleged victim and/or contact with students.

A report of child abuse or information relating to child abuse contained in a report, when provided to a law enforcement agency, shall not be subject to public inspection under Georgia Open Records Act even though such report or information is contained in or part of closed records compiled for law enforcement or prosecution purposes unless specific mandates of Georgia Law, O.C.G.A. 19-7-5 can be established.

iv. Cherokee County Department of Juvenile Justice
220 Brown Industrial Parkway, Suite 100, Canton, GA 30114; (770) 720-3556 phone; (678) 717-6639 fax

When any employee believes or becomes aware of any suspected neglect, physical, emotional or sexual abuse of a child under the age of eighteen (18), that employee shall immediately report such neglect or abuse to the DFCS. The report shall contain the following:

- the names and addresses of the child and the parent/guardian, if known,
- the child's date of birth,
- the nature and extent of the suspected abuse/neglect and
- any other information that the employee believes would be helpful

The State intake line (1-855-GACHILD) is available 24 hours a day, 7 days a week to accept referrals.

Questioning should be limited to only enough information to allow the employee to make an appropriate referral. An investigation as to whether abuse occurred is to be left to DFCS or law enforcement.

v. Cherokee County Mental Health Services
Highland Rivers, 191 Lamar Haley Parkway, Canton, Georgia 30114; 770-704-1600

If a child discloses sexual abuse or severe physical abuse during psychotherapy or counseling, the mental health provider should NOT attempt a forensic interview. The provider should not question the child in detail about the alleged abuse or attempt to use anatomically correct dolls for investigative purposes. Instead, a referral to DFCS or law enforcement should be made immediately. The mental health provider should reassure the child and prepare him/her for a possible forensic interview by a third party.

Any member of the staff who receives information concerning child abuse or neglect is to immediately report as follows:

1. Therapists should report directly to the State Intake line (855-GACHILD) and notify their supervisor.
2. Clerical staff or other support staff should report the incident or information directly to supervisory staff, to be reported to DFCS within 24 hours.

An immediate response from DFCS is required prior to the child's departure if danger of further abuse and neglect is suspected. Information necessary for agency's investigation of the abuse or neglect is to be shared.

vi. Cherokee County Probation Services
Canton Probation (Felony), 100 Medical Lane, Suite 1, Canton, GA 30114; 770-479-2602
Cherokee Probation Services (Misdemeanor), 959 Marietta Highway, Canton, GA 30114; 678-493-4300

When any employee believes or becomes aware of any suspected neglect, physical, emotional or sexual abuse of a child under the age of eighteen (18), that employee shall immediately report such neglect or abuse to the DFCS. The report shall contain the following:

- the names and addresses of the child and the parent/guardian, if known,
- the child's date of birth,
- the nature and extent of the suspected abuse/neglect and
- any other information that the employee believes would be helpful

If the parent/guardian is on active probation, the suspected abuse/neglect and subsequent report to DFCS should be documented in the field notes and maintained as confidential information. The report should not be filed while in the presence of the suspected abuser.

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

vii. Cherokee County Prosecution Offices
Office of the District Attorney, 90 North Street, Suite 390, Canton, Georgia, 30114; 648-493-6300
Office of the Solicitor-General, 100 North Street, Canton, Georgia, 30114; 678-493-6360

In all cases involving offenses of child abuse or neglect, the prosecutor handling the case should contact DFCS to inquire whether a referral has been made. If no referral was previously made by another agency, then the prosecutor is to make a referral. In any other case, when information comes to the attention of a prosecutor that a child is being abused or neglected, the prosecutor should make a referral to DFCS. In cases involving drug offenses, a referral

should be made by the prosecutor to DFCS if the child was present during any drug activity.

Cases involving human trafficking/commercial exploitation of children (CSEC) should be reported following the protocol set out under the section Commercial Sexual Exploitation of Children (CSEC) Response.

viii. Cherokee County Fire and Emergency Services

150 Chattin Drive, Canton, Georgia 30115, 678-493-4000

As the emergency medical provider for Cherokee County, the Fire and Emergency Services will focus on providing emergency medical care to the child upon our arrival. During this process, indications of child abuse or neglect will be documented. An oral report will be given to law enforcement if they are on the scene or to the physician upon arrival at the receiving medical facility as to what indicators were present and warrant further review.

If, after examination of the child on the scene for emergency medical treatment, it is determined that treatment is necessary, emergency medical personnel will initiate a standard of care that is medically necessary to stabilize the child and prepare the child for transport to a medical facility.

If during the assessment of the child any indicators of abuse should arise, the medical personnel will immediately notify law enforcement having jurisdiction and the on shift Medical Commander for the Fire and Emergency Services. If it is determined that the child does warrant transport to a medical facility and the legal guardian refuses to allow transport or treatment, the emergency medical personnel will ask for law enforcement intervention.

Upon completion of the call, a Patient Care Report and if necessary, a written supplemental report will be completed. These reports will include initial findings, treatment provided and any information needed to substantiate suspicions of abuse. These reports will be available upon request to appropriate authorities within the HIPAA guidelines.

5. INVESTIGATIVE AND ASSESSMENT PROCEDURES

a) Guidelines for Joint Investigation between Law Enforcement and DFCS

Joint investigation and cooperation between law enforcement and DFCS is vital to the goal of protecting the victim and preparing a solid court case. Each report of child abuse brings with it its own set of circumstances, therefore making each report unique in some way. Agencies will refer to this protocol, their own set of policies, and consult with other agency policies and law when presented with these obstacles.

Initial Response:

- In cases where law enforcement receives the report of abuse, they will report the referral to DFCS.
- An initial screening of the referral should be conducted.
- Contact should be made with the reporter whenever possible to assess the accuracy of the referral, safety of the child and other issues that may influence the interview.
- Law enforcement will check their records for previous records or histories with the family.
- Law enforcement and DFCS will meet and discuss the case and decide how to proceed with the investigation.
- Law enforcement or DFCS will schedule an interview at the Child Advocacy Center or designated equipped location within 24 hours.
- If the interview does not take place within 24 hours, Law Enforcement will assist DFCS with protection of the victim if necessary.

b) Department of Family and Children's Services

i. Investigation of Reports:

1. Reports of physical abuse and sexual abuse are reported by telephone by case manager to law enforcement. A joint decision is made as to law enforcement's involvement in the initial contact. If law enforcement does not participate in the initial contact, DFCS notifies law enforcement if their assistance is needed based on additional information received after contact.
2. Representatives from law enforcement will meet with DFCS to discuss/review cases assigned for DFCS investigation as needed.
3. Severe physical and all sexual abuse will be referred to the Child Advocacy Center or other

designated location. <u>In situations where there is the potential for medical evidence to exist, or when it is in the child's best interest, there should be a joint decision by law enforcement and DFCS to seek a medical examination.</u> DFCS and law enforcement will jointly decide whether a forensic interview is necessary based on the disclosure of the child.

4. In other cases of reports of physical abuse, DFCS will make the initial contact. Law enforcement will be contacted immediately if marks/bruises are severe. In cases where medical treatment is needed or the cause of injury cannot be determined, a medical opinion will be sought.
5. Law enforcement will be contacted if needed for securing parental cooperation, access to child or protection of the child.

ii. Interviewing Children at School:

1. When planning to interview the child at school, the DFCS case manager will contact a counselor or administrator upon arrival at school to arrange the interview. The DFCS case manager will be required to show their badge/proof of employment.
2. DFCS case manager will notify parents/caregivers as soon as possible after the interview.
3. If the child discloses that the abuse is by a parent/caregiver, steps need to be taken to protect the child and the disclosure. A child should not be returned home to an offending parent/caregiver without DFCS determining if and under what circumstances the child can return home.

iii. Investigative Reports:

1. In reports where maltreatment has been indicated and the risk to the child is able to be mitigated, the CPS case manager may develop a safety plan to reduce the risk to the child in the least restrictive way possible. The plan must be agreed to and signed by the caretaker. If caretaker does not agree, DFCS will seek relief from the court.
2. In cases where the risk is not able to be mitigated, a petition for deprivation may be filed with Juvenile Court.
3. Cases determined to be low risk will be closed and the case manager will refer the family to community resources.
4. Cases determined to be moderate to high risk where a safety plan is signed and agreed to by caregiver may be opened for family preservation services. DFCS will provide on-going child protective services. If caretaker later refuses to follow plan and risk to child increases, law enforcement and/or Juvenile Court assistance may be sought.
5. In all cases of sexual abuse with non-believing or non-cooperative non-offending caregiver(s), DFCS will immediately seek a suitable safety resource for the child. If there is no suitable safety resource available, then DFCS will seek an emergency order or file a petition in Juvenile Court for protection, cooperation, or custody.

c) <u>Basic Procedures for Law Enforcement Investigation of Child Abuse</u>

1. Responding officers shall meet with the complainant to obtain basic information (name, DOB, addresses, phone numbers, etc.) of any involved parties and witnesses, as well as any information about the allegation of abuse.

    a. If the report is made from a hospital or other medical facility, law enforcement will communicate with medical staff to obtain basic information.
    b. Such information will be obtained out of hearing range of the victim.
    c. Due to the nature of child abuse investigations, responding officers shall only gather basic information before turning the case over to a detective.
    d. To minimize trauma to potential victims, uniform officers shall take care not to interview victims regarding allegations of abuse but should instead obtain information from non-offending adults.
    e. If necessary, a minimal facts (only basic, non-detailed, open-ended questions) interview will be conducted before referring the victim to a forensic interview.
    f. Responding officers should then contact his/her supervisor so that they can notify an investigator.
    g. Responding officers will complete the initial report.

2. Responding officers shall immediately consider the child's safety and arrange for medical attention if needed.

    a. To notify DFCS or request an immediate response, responding officers may call 1-855-GACHILD.
    b. When a child is in <u>imminent danger of abuse or neglect if he or she remains in the home</u>, law enforcement should take a child into protective custody (pursuant to O.C.G.A § 15-11-133, see Appendix I) by calling DFCS and then calling the Cherokee County Juvenile Court Intake Officer (404-539-8981). Note: this is NOT DJJ intake, do not call DJJ.
    c. If the child is not in imminent danger, then DFCS only needs to be notified.

3. Interviewing a Child at School:

    a. If an investigator needs to conduct a minimal facts interview with a child at school, the investigator should contact Cherokee County School Police at 770-704-4346 in order to make arrangements.
    b. During this call, law enforcement investigators should inform Cherokee County School Police that they are investigating child abuse allegations and School Police will dispatch the appropriate Student Resource Officer (SRO).
    c. The SRO will speak directly with the law enforcement investigator and will assist in coordinating contact with the involved student. The SRO will be responsible for informing school administration that they are not to notify the parents/guardians of the interview or investigation.

4. If the offense occurred outside of the responding officer's jurisdiction, responding officers will advise the complainant and assist with filing a report with the appropriate law enforcement agency.

5. Investigative officers will investigate to determine if the allegation of sexual abuse, physical abuse or neglect is founded by probable cause. Steps include:

    a. Obtaining statements from victim through a trained forensic interviewer.
    b. Referring for a medical examination.
    c. Consulting with and documenting information gathered from medical professionals (i.e., primary pediatrician, emergency room doctor, child abuse pediatrician). Secure physical evidence from medical personnel if available.
    d. Interviewing all witnesses the victim has disclosed the abuse to, including but not limited to school personnel, medical personnel, friends, caregivers, parents, etc.
        i. Refer child witnesses for forensic interviews where appropriate.
        ii. Collect any written or recorded documentation which corroborates the victim's disclosure.
    e. Identifying and responding to the scene to observe, record, photograph, document, and collect evidence, even if the disclosure of abuse is historical.
    f. Obtaining and executing any applicable search warrants for evidence to include known offender samples, corroborating evidence from scene or location (including photos), or any digital evidence (such as cell phones).
    g. Interviewing suspect when identified using video and/or audio recording. Document all attempts to contact the suspect and whether they were unwilling to participate in an interview.
    h. Obtaining arrest warrants and apprehending suspect.
        i. Arresting officer should request special conditions of bond to include no contact with the victim, a no contact with any children under the age of 18 years, and any other appropriate conditions.
    i. Collaborating with District Attorney's or Solicitor's Office to identify necessary evidence for prosecution purposes which may be lost and not available for trial if not gathered during the initial stages of the investigation.
    j. Checking criminal history and compiling case file for prosecution.
    k. Participating in subsequent judicial proceedings.

d) Forensic Interview Procedures

A forensic interview is a research-based process conducted by a trained interviewer at a Children's Advocacy Center or other location that has trained forensic interviewers. The forensic interview is developmentally, culturally, and linguistically appropriate and allows for the child's narrative recall of events. The goal of the forensic interview is to obtain a statement from the child, in a sensitive and unbiased manner that will support accurate and fair decision making in the criminal justice and child protection systems. The forensic interview is conducted in a legally defensible and non-leading manner and is video recorded.

i. The Child Advocacy Center

Anna Crawford Child Advocacy Center, 9870 Hwy. 92, Ste. 200, Woodstock, Ga. 30188; 678-504-6388

The Child Advocacy Center is an integral part of the joint investigation between DFCS and law enforcement. When an interview of a child is required at any time during the investigation, it must be done through a Child Advocacy Center or other location that has trained forensic interviewers.

In general, children most appropriate for a forensic interview include children for whom there are concerns regarding the following: physical abuse with injuries, severe negligence, emotional abuse, sexual abuse, sexual exploitation and/or abduction or witness to any type of violence including but not limited to domestic violence, sexual assault and murder. Children who have made a disclosure regarding the above types of abuse, or who have medical evidence of abuse, or who exhibit behaviors suggestive of abuse should be referred for a joint forensic investigation of the abuse by DFCS and law enforcement.

Forensic interviewing is a practice continually enhanced by emerging research. Law enforcement and DFCS personnel should make every effort to follow CAC procedures and to coordinate their investigative efforts in a manner which increases the efficiency of the investigation while minimizing additional trauma to the child. Alleged victims of sexual abuse or severe physical abuse will also receive multidisciplinary response coordinated through the Children's Advocacy Center, DFCS or other designated entity. See below section on Multi-Disciplinary Team (MDT).

ii. The Forensic Interview

1. Required Training

A forensic interview is to be performed by someone trained in forensic interviewing through specialized training programs such as ChildFirst (formerly known as Finding Words). ChildFirst is an intensive five-day course in which students learn the necessary skills to conduct an investigative, forensic interview of a suspected victim of child abuse. Additional nationally recognized forensic interview training courses include programs such as the National Children's Advocacy Center (NCAC), Tom Lyon's Ten Step Model, CornerHouse, the National Institute of Child Health Development (NICHD) and the American Professional Society of Abuse of Children (APSAC).

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

Some of these areas include:

- process of disclosure of abuse
- signs, symptoms and dynamics of child abuse and neglect
- children's memory and suggestibility
- dynamics and techniques related to interviewing children of specific age groups and children with special needs
- characteristics of abuse and neglect
- manipulative grooming
- coaching/false denials/false allegations
- criminal codes
- effect of childhood trauma and stress
- recantation
- techniques to minimize interviewer bias
- cultural considerations in interviewing
- factors related to interviewing children who have been commercially sexually exploited

The competence and objectivity of interviewers and the quality of the interview itself are frequently the focus of abuse investigations. Because most perpetrators deny the abuse and most acts of maltreatment are not witnessed, the alleged victim's statement is critical evidence in child abuse cases. Developmental issues, such as children's varying abilities to recall events and use language, as well as the trauma they may have experienced, complicate efforts to obtain information about the abuse. Forensic interviewers are trained to have knowledge of these dynamics and of techniques that aim to maximize the competency of children.

Trained forensic interviewers should be utilized to conduct forensic sexual abuse interviews of children. Opportunities for training are available. Please contact the Anna Crawford Children's Center (ChildFirst Georgia), the Office of Child Advocate or the Children's Advocacy Centers of Georgia for training information.

The child victim and his or her legal guardian should be made aware that even though the forensic interview has been, or will be, conducted and recorded, this process may not take the place of the child having to testify if the case goes to trial.

2. Referrals to the Child Advocacy Center

Children for whom there are concerns or who have made a disclosure regarding physical abuse with injuries, severe neglect, emotional abuse, sexual abuse, or sexual exploitation and/or abduction, or who have witnessed violent crime including domestic violence, sexual assault, or murder, or children who exhibit behaviors suggestive of abuse should be referred for a joint investigation by DFCS and law enforcement.

Children 3 or under or who are insufficiently verbal for an interview but who present with medical evidence or sexualized behaviors should be referred by law enforcement and/or DFCS for multidisciplinary review by contacting the Children's Advocacy Center.

Video recorded sexual abuse forensic interviews of children 3-17 should be conducted at the Anna Crawford Children's Center (ACCC) or another Children's Advocacy Center and will only be scheduled at the request of DFCS, law enforcement, the district attorney's office or the Court. The Anna Crawford Children's Center is also available to interview children who are 18 if the individual is still in high school. The Anna Crawford Children's Center is also available to interview reported victims/witnesses who fall outside of the age ranges described above, based on special circumstances that may include adults with special needs who may have experienced abuse or exploitation.

ACCC is also available to interview young adults where there is an investigation regarding historical allegations of abuse or possible witness to a crime. While developmental factors may not play a role in their current communication skills, young adults disclosing historical incidents of abuse would be required to recount memories that were coded with the language/verbal skills that they had at the time of the reported incident(s). Therefore, specialized knowledge regarding child development is necessary when attempting to gain information under these circumstances.

While it is preferable for reported child victims to be interviewed at ACCC, if circumstances require immediate response, children 14-17 may be interviewed by a trained interviewer at an agency location. However, these cases should be referred to the Children's Advocacy Center for interdisciplinary case coordination and follow-up victim services the following business day.

Intake reports should be made to the Children's Advocacy Center staff who will schedule an interview time. To ensure that all relevant information is obtained in the initial interview, all team members involved in the investigation should be present.

ACCC does not interview alleged perpetrators. However, children under 16 who are sexually acting out with other children or who have sexual behavior problems may be interviewed for assessment of possible victimization. Children over 16, or those who display coercive or predatory type sexualized behaviors, will be referred to another agency for a psychosexual evaluation. In cases involving children with sexual behavior problems, the referring agency should alert the ACCC staff to this matter when scheduling the interview so that additional precautions can be taken to ensure the safety of all children. Referrals can be made by DFCS, law enforcement, the District Attorney's office, Solicitor's Office, the Juvenile &/or Superior Court, Department of Juvenile Justice and Adult Protective Services. An interview time will be scheduled. Although both DFCS and law enforcement should be present to ensure all relevant information is obtained, a representative of the referring agency must attend.

3. Live Viewing of Forensic Interviews

To ensure that all relevant information is obtained, all team members involved in the initial investigation should be present and observe the forensic interview. However, a minimum of one representative from law enforcement, child protective services or the prosecuting attorney's office must be present for the interview to take place. In the event an investigative team member is unable to attend the interview, he/she will have access to the digitally recorded interview and written intake packet. Additionally, any involved team member unable to attend the interviews is responsible for communicating with the other team members if further information or clarification is required. This coordinated approach seeks to reduce the number of interviews conducted with the child, reduce the possible trauma to the child, and maximize the efficiency and effectiveness of the investigative process.

Forensic interviews may be observed by members of the multidisciplinary team which may include representatives from child protective services, law enforcement, the Solicitor's Office, the District Attorney's Office, the Anna Crawford Children's Center, and CHOA medical professionals.

Non-offending caregivers may accompany the child to the Center but are not allowed to be present with the child during the interview nor are they allowed to observe the interview.

Known alleged offenders should not transport clients to the interview and are not allowed on the premises of the ACCC.

4. Documentation of Forensic Interviews

All forensic interviews are to be digitally recorded with video equipment provided by the Anna Crawford Children's Center. The assigned caseworker and law enforcement investigator assigned to the case will have access to observe the interview from a separate viewing room. Once recording has begun, it should not be discontinued until the interview is completed. Upon completion of the interview, ACCC staff will email the original, authenticated recording of the forensic interview video to the assigned law enforcement investigator through a HIPAA compliant Box account. If requested, ACCC will email an original, authenticated recording of the interview to the prosecuting attorney's office. ACCC staff will not release the forensic interview to any other party unless legally compelled.

5. Confidentiality and Access to Child Abuse Records

The CAC which is certified and operated for the purpose of investigation of known or suspected child abuse and treatment of a child or a family which is the subject of a report of abuse shall have access to all records and information relevant to the child's case with few exceptions; provided, however, that any child advocacy center which is granted access to records concerning reports of child abuse shall be subject to the confidentiality provisions of subsection O.C.G.A. § 49-5-40(b) and shall be subject to the penalties imposed by O.C.G.A. § 49-5-44 for authorizing or permitting unauthorized access to or use of such records. O.C.G.A. §49-5-41 (a)(8).

6. Release and/or Providing Access to View the Forensic Interview

ACCC will only release recorded forensic interviews to law enforcement and the prosecuting attorney's office. O.C.G.A. § 49-5-41(c)(5) otherwise dictates the proper procedure for access and release of protected child abuse records. ACCC will make forensic interviews available for viewing for appropriate parties where necessary and with a proper court order.

7. Forensic Interviews and Special Populations

a. Sexually Exploited Children

Although normally best practice suggests that children should have a forensic interview as soon as possible, interviews with children who have been sexually exploited may require an interval of time to assess their readiness to be interviewed. More than one forensic interview may be required due to dynamics related to exploitation. Sexually exploited children are often pimped/trafficked. Pimps/traffickers may teach victims to be distrustful of health/social service providers, police, and government officials. Victims of exploitation may believe that revealing what has happened to them will result in arrest and detention for prostitution, particularly if interviews are conducted in an interrogative tone. Further, many children have a "love" relationship with their exploiter and may fear that the state may incarcerate them if they are truthful.

An additional complication is that sexual exploitation victims are frequently brought into the system as suspects or arrestees and some interviews initially take the tone of interrogation. This may make children reluctant to believe the state is trying to help them. Effective information gathering requires that service providers and interviewers work to empower the child and help him/her understand their "victimization." Trust should be established over time, and the formal forensic interview needs to occur after this trust has been established.

The Children's Advocacy Centers of Georgia (CACGA) Commercial Sexual Exploitations of Children (CSEC) Response Team is a statewide system of care for victims of sexual exploitation and can help to connect you with victim advocates, family advocates, and specialized services providers who can assist in preparing the child for a forensic interview.

Format and dynamics of this type of interview are different than traditional sexual abuse cases, because:

- Victims most likely has lengthy history of abuse/neglect and may feel the abuse that they have "chosen" by running to the streets or finding a pimp is preferable to the abuse they suffered at home. As a result, they often refuse to identify themselves as victims;
- Victims have a strong distrust of authority;
- Victims may fear for the safety of their families or others due to threats made by a pimp; and
- Adolescents often reject any outreach that is perceived as condescending.

Child protection is paramount throughout the investigation.

b. Children with Special Needs

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

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

The American Professional Society on the Abuse of Children (APSAC) recommends practice guidelines for interviewing special needs children which include making appropriate accommodations, making medical consults if needed, and assessing developmental delay through consultations. APSAC also views the adaptive equipment involved in the communication with the alleged child victim as an extension of the child's body.

The National Victim Advocacy Agency, co-sponsored with the United States Department of Justice, has also advised accommodations of special needs children. They recommend agencies should develop and implement specific protocols on disclosure, confidentiality, and safety for crime victims with disabilities, particularly where there is potential for retaliation by the caregiver.

8. Extended/Multiple Sessions Forensic Interviews

The Anna Crawford Children's Center recognizes that the number of forensic interviews should be governed by the number necessary to elicit information needed to make child protective and investigative decisions.

Regardless of the number of sessions, all forensic interviews should abide by the following best practices:

- Purposeful in nature (a valid reason can be articulated for conducting more than one interview)
- Forensically sound
- Non-duplicative
- Neutral and objective
- Child-friendly
- Child- focused

- Developmentally appropriate
- Culturally competent

At times the investigative team may determine that multiple forensic interviews are warranted. Potential reasons to conduct more than one session may include, but are not limited to, the following:

- Decision-making regarding the protection of the child cannot be made based upon information obtained during the initial interview.
- An interview could not be completed in one session due to the child's level of engagement/participation, developmental/cognitive abilities, social/emotional/physical functioning, or another reason information could not be fully or effectively gathered in the single session.
- The child may need additional time due to victimization type (CSEC victims, long-term victims, polyvictims).
- The child disclosed additional information or indicated the reason he/she could not tell, or due to changes in the situation/circumstances, or external evidence or corroboration emerges.
- The child did not disclose abuse during the initial forensic interview but there are concerning factors of possible victimization such as sexualized behaviors, medical findings, statements of other children and/or witnesses, images of child sexual abuse, or access by a known offender.
- The child did not disclose abuse during the initial forensic interview but allegedly disclosed to some other person.
- The child was unable to complete the forensic interview in one session and needs additional time.
- The child disclosed additional information following the initial forensic interview. While disclosure is a process and it is common for children to reveal additional information over time, the disclosure of significant details may warrant an additional interview to allow for investigative or protective decision-making.

Under some circumstances, multiple forensic sessions may also be planned from the beginning and carried out over 2-6 sessions (typically as dictated by the needs of the child) to address and fit a particular child's needs such as age, developmental disabilities or other special needs, ability to communicate, being multi-lingual and/or requiring an interpreter, multiple allegations/offenders and/or types of abuse, and for those who have been severely traumatized.

Following the conducting of an initial forensic interview, the investigating agencies (i.e., law enforcement, DFCS, and/or prosecution) will refer an alleged child abuse victim for additional forensic interview sessions when deemed necessary. Additional forensic interview sessions will be scheduled at the request of DFCS, law enforcement, and the prosecuting attorney's office only.

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

Non- offending caregivers may accompany the child to the Child Advocacy Center but are not allowed to be present or observe additional forensic interview sessions. While additional forensic interviews are being scheduled and conducted, it is preferable that the child have no contact with alleged offender(s), if identified at the time.

All involved investigators will provide the forensic interviewer with case information including the nature and circumstances of the allegations, and any possible alternative explanations for the allegations.

During the time that additional forensic interviews are being conducted with the child, any new information disclosed during the process pertaining to the abuse allegations should be immediately relayed to the involved investigative team members for follow up.

9. Multi-Disciplinary Team (MDT)

Upon completion of the forensic interview process, the multidisciplinary team makes recommendations regarding the child's need for medical and mental health treatment.

a. What is a Multi-Disciplinary Team

A multi-disciplinary team is a group of professionals representing various disciplines who work collaboratively to promote a thorough understanding of case issues and assure the most effective system response possible. The

purpose of interagency collaboration is to coordinate intervention to reduce potential trauma to children and families, while preserving and respecting the rights and obligations of each agency.[1]

The MDT consists of law enforcement officers, child protective service investigators, prosecutors, mental health and medical professionals, and others who provide a coordinated response designed to increase the effectiveness of investigations while reducing the stress and risk of secondary traumatization to children.[2]

b. Coordination of MDT Meetings

The Anna Crawford Children's Center will coordinate multidisciplinary team meetings for the primary purpose of facilitating communication between agencies involved in the investigation and prosecution of allegations of child maltreatment as well as those agencies responsible for protecting child victims. Monthly MDT staffing will provide agency members with a forum to discuss complex cases with other professionals, and as a result, will enhance both the decision-making and intervention processes.

MDT meetings will be held at the Anna Crawford Children's Center, and an agenda identifying cases to be staffed at each meeting will be provided to all involved agencies at least 48 hours prior to the regularly scheduled monthly meeting.

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

c. MDT Staffing

MDT members may request to staff any case they believe can benefit from the collaborative input of the team. Requests can include cases involving children who were not seen for services at the Center if there is an active investigation. Requests for cases to be staffed by the MDT are accepted from any MDT member and/or appropriate agencies. Appropriate referral sources include, but are not limited to, DFCS, Board of Education, law enforcement, District Attorney's office, the Child Advocacy Center, the Department of Juvenile Justice, and medical and mental health personnel.

A special MDT staffing may be called by the prosecuting attorney's office representative if circumstances change prior to indictment.

Because the purpose of the MDT staffing is to facilitate the sharing of information between agencies, all individuals from DFCS, law enforcement, prosecution, medical, and mental health that are involved with a case being staffed should be present.

10. Commercial Sexual Exploitation of Children (CSEC) Multi-Disciplinary Team

To better address the complex issue of CSEC, the Cherokee County Child Abuse Protocol hereby incorporates and grants concurrent authority to address these cases to the Children's Healthcare of Atlanta (CHOA) Stephanie V. Blank Center for Safe and Healthy Children Commercial Sexual Exploitation of Children Multi-Disciplinary Team. Further, the Cherokee County Child Abuse Protocol incorporates and grants concurrent authority to address these cases to the Children's Advocacy Centers of Georgia (CACGA) Commercial Sexual Exploitations of Children (CSEC) Response Team. Both the CSEC MDT and the CACGA CSEC Response Team may address any cases of suspected commercial sexual exploitation within Cherokee County.

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[1] Putting Standards into Practice: A Guide to Implementing the 2023 National Standards of Accreditation for Children's Advocacy Centers; National Children's Alliance; 2023.

[2] Children's Advocacy Centers: One Model, Many Programs APSAC Advisor; Volume 16, Number 2; Summer 2003 Wendy Walsh, Lisa Jones, and Theodore Cross, Crimes Against Children Research Center, University of New Hampshire. See also, Children's Advocacy Center for Georgia, Handbook for Multidisciplinary Review Team Facilitators.

While the Cherokee County MDT will still staff CSEC cases, the goal of including the CHOA MDT and the CACGA CSEC Response Team in our practices is to provide a specific and more focused response to CSEC cases to best address the unique needs of victims and to closely monitor the progress of each as services are provided to them.

e) Obtainment of Forensic Medical Exams/Sexual Assault Exams

i. Examination

The forensic medical exam is an important part of the investigative process which aims to provide the best health care for the child and the soundest documentation and interpretation of findings. However, a victim-centered approach should be utilized, allowing the child to have a say in whether they have an exam. Forensic medical exams and sexual assault exams should be provided utilizing a trauma-informed, culturally sensitive, rights-based approach. Ability to pay is never a factor in determining who is referred for a medical evaluation.

All children who are suspected victims of child abuse should be assessed to determine the need for a medical evaluation.

Sexual Abuse/Assault

- A sexual abuse medical exam is indicated when a child reports a contact sexual offense, or when a witness (including the offender) reports observing such an offense to the child. A decision to obtain a medical exam should not depend solely on whether there is a report of "genital to genital contact" as this information may be difficult to ascertain and children may minimize the extent of contact. Further, certain sexually transmitted diseases may be spread through contact, not only through penetration.
- A forensic medical exam may also be indicated when the child has been involved in a high-risk situation or has non-specific physical complaints or visible symptoms, such as burning or redness in the genital or anal areas.
- Caregivers may also be advised to have young children or children with special needs seen for a sexual abuse medical exam when there are concerns of sexual abuse, without the presence of the above-mentioned circumstances, due to the increased vulnerability of children who are non-verbal or who have limited or impaired communication skills.
- In the absence of a disclosure, a forensic medical exam is indicated when a caregiver or investigative team members continue to have concerns that the child may have been sexually abused.
- A medical evaluation is indicated when a child lives in the same household as an allegedly abused child and/or has had access to the alleged perpetrator.

Physical Abuse

- Children who have signs/symptoms of possible intracranial injury, acute fracture, abdominal trauma, significant burn, or other serious medical condition requiring extensive evaluation and immediate treatment need to be evaluated at an Emergency Department.
- Suspected victims of physical abuse who have (or who are reported to have) cutaneous injuries (old or new) that do not require suturing or other medical procedure may be referred to Children's Healthcare of Atlanta's Stephanie V. Blank Center for Safe and Healthy Children.
- Siblings and other children who live in the home of a suspected abuse victim, or who have had access to the alleged perpetrator.
- Children who have been had an inpatient hospitalization for concerns of physical abuse that require follow-up or additional testing.

Neglect

- Any child for whom there are concerns of significant physical, environmental, supervisory, educational, or emotional neglect who require emergency medical treatment should be referred for evaluation at an Emergency Department.
- Any child for whom there are concerns of significant physical, environmental, supervisory, educational, or emotional neglect who do not require emergency medical treatment may be referred for evaluation at an Emergency Department.
- Siblings of suspected neglect victims, and other children living in the home may also need medical exams.

There may be exceptions to these recommendations. Before deciding against a medical exam, the MDT should discuss the case with an expert medical provider from Children's Healthcare of Atlanta's Stephanie V. Blank Center for Safe and Healthy Children.

ii. Purpose

There are multiple purposes of forensic medical exams:

- Ensure the health, safety and well-being of the child;
- Screen for injuries and medical conditions; initiate medical treatment, when warranted, which may include providing referrals;
- Identify and collect medical evidence using magnification and photo documentation; and
- Answer questions and reassure victims and parents about the child's physical well-being and findings of the exam.

The medical exam typically begins with the examiner obtaining a thorough medical history of the victim. The medical exam also involves a head-to-toe exam, including the genital area. The exam may also include:

- Collection of blood, urine, hair and other body secretion samples
- Magnification and photo documentation
- Collection of the victim's clothing and undergarments
- Collection of any possible physical evidence that may have transferred onto the victim

Law enforcement should advise the examiner regarding any specific evidence to attempt to collect based on the facts of the case.

iii. Who Can Conduct the Forensic Medical Exam?

While the physician, nurse practitioner or physician assistant providing care for the child can conduct the medical evaluation, it is preferable for the evaluation to be performed by a provider with expertise in child maltreatment. Experts include child abuse physicians, or other physicians, nurse practitioners or physician assistants with specialized training and experience in child abuse and neglect, or sexual assault nurse examiners (SANE). Medical professionals are encouraged to seek help from experts when possible by referring the patient for specialized care, by requesting telephone consultation, and/or by obtaining a second opinion review of exam photographs.

iv. Timing of the Medical Exam and Referral Process

a. Sexual Abuse/Assault

Forensic medical exams should be offered in most cases of sexual abuse, regardless of the length of time that may have elapsed between the most-recently reported or suspected sexual contact and the examination.

Forensic medical examinations are usually recommended as soon as possible after the assault but within 120 hours because passage of time and the healing process can obscure medical evidence (trace evidence and physical injury) and decrease the effectiveness of prophylactic medications. Of note, there is research to indicate that forensic exam evidence may be available for collection up to 10 days.

Law enforcement should consult with the medical provider to determine the need for evidence collection.

The child should have prompt evaluation if he or she has symptoms or signs of injury, infection, or another active medical condition.

Importantly, regardless of the length of time passed, the referral of children for medical exams should not be limited to those for which the collection of forensically significant evidence is anticipated.

Referrals for examinations can be differentiated and addressed based on the following criteria and guidelines:

1. Emergent (without delay, i.e., injury or mental health concern requiring emergency medical attention)

Reasons for emergency evaluation include, but are not limited to:

- Medical or mental health intervention is needed emergently to assure the health and safety of the child;
- The child complains of pain in the genital or anal area;
- There is evidence or complaint of anogenital bleeding or injury;
- The child is experiencing significant behavioral or emotional problems and needs evaluation for possible suicidal ideation/plan.

For **EMERGENT** exams, children should be transported to the emergency department of the nearest hospital or to the emergency department of Children's Healthcare of Atlanta.

Northside Cherokee Hospital - 450 Northside Cherokee Blvd, Canton, GA 30115, (770) 224-1000
Children's Healthcare of Atlanta Emergency Department - 1001 Johnson Ferry Rd NE, Atlanta, GA 30342, (404) 785-2273

2. Non-Emergent:

a. Urgent: acute, scheduled as soon as possible with qualified medical provider, i.e., a recent incident of sexual abuse or assault suspected to have occurred within the last 120 hours

Reasons for urgent exams include, but are not limited to:

- The alleged assault may have occurred within the previous 120 hours, and the transfer of trace evidence may have occurred which will be collected for later forensic analysis;
- The need for emergency contraception;
- The need for post-exposure prophylaxis for STI (sexually transmitted infections) including HIV;

b. Non-urgent: non-acute, alleged abuse/assault occurred more than 120 hours ago, no complaints of vaginal/penile/rectal pain or discharge
   - Scheduled at convenience of family and provider but ideally as soon as possible, within the first few weeks of initiation of investigation, when possible.
   - These children should not be sent to an Emergency Department.

For **NON-EMERGENT** exams, the Cherokee County MDT will refer children to the following agencies, based on criteria detailed below:

1. Children's Healthcare of Atlanta (CHOA) Stephanie V. Blank Center for Safe and Healthy Children

The Stephanie V. Blank Center for Safe and Healthy Children is a child advocacy center that provides comprehensive medical and forensic evaluations in acute and non-acute cases, in a safe, child-friendly environment staffed by a team of professionals with extensive pediatric experience.

For consultation and guidance on the timing or location for scheduling medical exams, contact the transfer center at Children's Healthcare of Atlanta at 404-785-7778.

The Center for Safe and Healthy Children provides several options for medical examinations:

a. Outpatient Examinations at CHOA Scottish Rite Campus

   CHOA Center for Safe and Healthy Children at Scottish Rite
   Northside Professional Center
   975 Johnson Ferry Road NE, Ste 350, Atlanta, GA 30342, 404-785-3820

   - By appointment only, Monday through Friday 8:30 a.m. to 4:30 p.m.
   - 24/7 After Hours Services - For acute, after-hours sexual assaults (less than 120 hours since assault), the on-call Center for Safe and Healthy Children nurse practitioner can see a patient in the Emergency Department, where colposcopy is also available.
   - Sexual abuse cases and physical abuse cases
   - Ability to perform colposcopy with digital photographs
   - Utilize Child Life Specialist to make exam as stress-free as possible
   - Written documentation of examination and medical opinion
   - Testing for possible sexually transmitted infections, when indicated
   - Treatment and prophylaxis, as needed

b. Outpatient Examinations at the Anna Crawford Children's Center

   A Center for Safe and Healthy Children physician can:
   - Consult on any child in a CHOA inpatient facility where there are concerns of child abuse

- Make recommendations to treating physicians regarding further work-up and management
- Provide written medical documentation of findings and opinion

c. <u>Inpatient Consultations at Children's Health Care of Atlanta</u>

(*by a Certified Pediatric Nurse Practitioner from the CHOA Center for Safe and Healthy Children)*
Anna Crawford Children's Center, 9870 Hwy 92, Ste 200, Woodstock, GA 30188, 678-504-6388

- By appointment/referral only
- Primarily non-acute sexual abuse cases
- Acute sexual abuse cases when presented during ACCC medical exam clinic hours may be seen at the Center or may be referred to the Center for Safe and Healthy Children or LiveSafe, based on the medical needs of the child
- Sexual abuse cases, physical abuse cases are also seen
- Ability to perform colposcopy with digital photographs
- Utilize advocacy and support staff to make exam as stress-free as possible
- Written documentation of examination and medical opinion
- Testing for possible sexually transmitted infections, when indicated
- Plan for Treatment and prophylaxis, as needed

Anna Crawford Children's Center (ACCC) will provide forensic medical evaluations for children from infancy up to the age of 18, at NO CHARGE through medical providers from Children's Healthcare of Atlanta. Medical exam services will be provided by CHOA certified pediatric nurse practitioners with extensive training in the area of child abuse.

The investigative referral source will communicate with the Anna Crawford Children's Center to request the medical exam and to provide necessary intake information. The referral source and ACCC staff will collaborate, based on the circumstances of each case, to determine who will communicate with the parent or caregiver to schedule the appointment.

A parent, legal guardian, or persons who have custody of the child must be present at the forensic medical examination appointment. If the above are unable to attend the appointment a letter stating their permission for another adult to bring the child for the evaluation must accompany the child or be sent in advance. Children who are in the protective custody of the authorities must be accompanied by either an employee of that agency or a foster parent. With the child's permission, a support person and/or an ACCC Advocate may be present in the exam room throughout the exam. The CHOA nurse practitioners will maintain internal CHOA protocol on performing medical forensic examination in accordance with the current evidence-based recommendations of practice.

2. <u>LiveSafe Resources - Sexual Assault Nurse Examiner Program</u>
48 Henderson Street, Marietta, GA 30064, 770-427-3390

Free acute medical forensic examinations for victims of sexual assault ages 13 years and older. Available 24 hours a day, 7 days a week.

Mission: to provide safety and healing to those impacted by domestic violence, sexual assault, and elder abuse by offering services, creating awareness, and fostering support within our community.

The Sexual Assault Nurse Examiner (SANE) program operates in conjunction with the LiveSafe Resources to serve female, male and intersex victims of sexual assault ages thirteen years and older. The SANE Program exists to meet the needs of the patient and law enforcement providing services for acute cases. Acute cases are any sexual assault which has occurred within 120 hours of the reported sexual assault or any aggravated sodomy cases within 72 hours of reported assault. Any case that presents outside the time frame of 72 or 120 hours requires a medical consultation with LiveSafe Resources SANE Program Manager to determine the next appropriate steps which may still involve evidence collection through a SANE Exam.

a) **Activation of SANE:**

- The SANE is activated by Law Enforcement (Detective/Investigator) with jurisdiction in Cherokee County.
- The SANE will activate a Sexual Assault Advocate to respond for the examination.
- The SANE Suite is located at LiveSafe Resources, 48 Henderson Street, Marietta, GA 30064.

- Access to the SANE Suite is gained by entering through the SANE Suite Door at the rear of the building. Law enforcement, SANE, and LiveSafe Resources Advocate may park in the designated spaces near the SANE exam suite.
- Law enforcement will wait until the SANE or LiveSafe Resources Advocate arrives to gain access to the SANE Suite.
- Any sexual assault victim with injuries requiring medical attention (i.e., fractures, lacerations, strangulation, etc. requiring treatment by physician or impaired by alcohol/drugs) will need to be transported to either Northside Hospital-Cherokee, Wellstar Kennestone Hospital or Children's Healthcare of Atlanta Emergency Room for treatment. If the sexual assault victim is transported to the Emergency Room, the SANE and Advocate can be activated to the hospital for the collection of evidence if the patient is unable to be discharged within a timely manner.
- Law enforcement should refer to local EMS protocols when determining whether a patient is stable enough to be transported to the exam site at LiveSafe Resources or the Emergency Room, or whether the victim's condition dictates the closest medical facility.
- Sexual assault victims cannot be received at LiveSafe Resources if transported by EMS.
- If present, law enforcement must remain at the exam site until such time as the exam is complete.
- Investigative bodies must take possession of the evidence at the conclusion of the SANE exam or per state law evidence must be retrieved within 96 hours and sent to the GBI Crime Lab within 30 days.

b) **Medical Accompaniment and Advocacy:**

Law enforcement personnel should not be present inside the exam room during the medical examination of the victim, except for cases in which the victim is in police custody. During exams with victims that are in custody, law enforcement personnel may become privy to private communications. The law enforcement officer inside the exam room should not be the same individual assigned to investigate the incident in which the exam is being performed. Some of these communications are protected by HIPAA and it is important for law enforcement in the room to note that protection and the victim's right to privacy of their medical history.

With the victim's permission, the LiveSafe Resources Sexual Assault Advocate may be present in the exam room throughout the exam. The LiveSafe Resources Advocate will explain to the victim his or her rights and options. The SANE will explain the nature of the evidence collection and the physical exam, pregnancy test, emergency contraception and other prophylactic medications to prevent sexually transmitted infections, and options regarding testing for HIV and hepatitis B.

The SANE will also discuss appropriate follow up care and recommended vaccinations. The LiveSafe Resources Advocate and SANE will discuss follow-up options with the victim, including referral to Anna Crawford Children's Center if the parent/guardian wishes to be referred.

The LiveSafe Resources Advocate will provide information regarding the emotional and physical reactions which the victim may experience and the types of assistance available to the victim and the parents/guardians of minor children.

The LiveSafe Resources Advocate provides the victim and those persons accompanying the victim with handouts explaining services available from LiveSafe Resources Sexual Assault Program and Anna Crawford Children's Center. The Advocate will also explain how the center will contact the victim or parent/guardian after they return home to assist them.

The LiveSafe Resources SANE Program will maintain internal protocol on performing medical forensic examination in accordance with the current evidence-based recommendations of practice.

b. Physical Abuse

In cases involving allegations of physical abuse, a medical exam may be necessary for either emergency medical treatment or evidentiary purposes.

1. Any child with suspected physical abuse who is less than one (1) year of age should be seen in the Emergency Department of the nearest hospital or the Emergency Department and Children's Healthcare of Atlanta.
2. A child who is bleeding, or who has suspected head, abdominal, or other internal injury, strangulation bruising, bone fracture, or significant burn should be seen immediately at the Emergency Department of the nearest hospital or the Emergency Department and Children's Healthcare of Atlanta.
3. Children who are otherwise stable but have suspicious skin injuries may be seen at the CHOA Center for Safe and Healthy Children or at the Anna Crawford Children's Center if there is scheduling availability. Suspicious skin injuries are those that:
    a. Have patterned appearance, OR

b. Are located on ordinarily protected areas of the body (facial cheeks, behind the ears, neck, torso, genitals, buttocks, thighs), OR
c. Involve the lips or mouth, OR
d. The child or other person alleges that the injuries are the result of inflicted trauma.

4. Photographs of all potentially abusive injuries should be taken as soon as possible after the investigation begins. Usually this will be done by Law Enforcement.
5. Children initially evaluated in the Emergency Department for physical abuse should be followed up at Children's Healthcare Center for Safe and Healthy Children or the Anna Crawford Children's Center at the next available appointment. Because the appearance of bruises and swelling can change quickly, photographs taken at presentation should accompany the child to the medical exam appointment so that they can be reviewed by the medical provider who can give an opinion about the likelihood of abuse.

c. Neglect

In cases involving allegations of neglect, a medical exam may be necessary for either emergency medical treatment or evidentiary purposes.

1. Children with signs and symptoms of difficulty breathing, abnormal behavior, bleeding, pain, or severe malnutrition should be seen in Emergency Department or call 911
2. Children with evidence of mild or moderate physical neglect may be evaluated at CHOA Center of Safe and Healthy Children or the Anna Crawford Children's Center. Both locations can provide an appropriate environment for evaluation of children without symptoms or immediate medical concerns, as a thorough exam with developmental screen and careful documentation of findings are available and staff members have time to gather important information before writing a full report.

For cases of physical abuse and neglect, the MDT members involved with the investigation will consult and determine the need for a medical exam and will determine if urgent medical treatment is necessary. When urgent treatment is deemed necessary, the lead investigator(s) (law enforcement and/or DFCS) will ensure the child is taken to the nearest emergency hospital or CHOA Emergency Department.

When the team determines a non-emergency medical exam is recommended, the team will appoint a specific team member who will take the lead in referring the child to the Center for Safe and Healthy Children (at CHOA or at the Anna Crawford Children's Center) for the medical examination. When the child is referred to a medical provider other than the Center for Safe and Healthy Children, the lead investigator(s) will be responsible for communicating with the facility to gather information regarding the condition of the child and any findings from the medical exam. This information will be shared with the necessary multidisciplinary team to inform immediate decision making and also at the regularly scheduled case review.

v. Evidence Collection

Sexual assault evidence kits are recommended when the assault involved the exchange of bodily fluids or trace evidence and occurred within the past 120 hours. Once the examination is completed and all specimen are collected, they should be carefully packaged and stored to assure that they are not contaminated. They should be maintained under chain of custody until further action is taken. Chain of custody is critical to the admissibility of evidence at trial. The sexual assault evidence collection kit should be sent to the GBI Crime Lab by the investigating law enforcement agency who has jurisdiction of the case. Victims of sexual assault may need to go to a hospital located outside of their county or state of residence or outside of the jurisdiction where the assault took place. The law enforcement agency in the jurisdiction where the assault occurred is the law enforcement agency charged with investigating the assault and facilitating transfer of the evidence collected from the hospital to the appropriate forensic lab in the jurisdiction where the assault took place.

f) <u>School District Involvement</u>

Child abuse-related interviews by DFCS, the District Attorney's Office, and/or law enforcement may be conducted at the school during school hours. For an outline of procedures to be followed by DFCS and law enforcement when seeking to interview children at school, see pages 11-12. In such cases, school staff should assist these agencies by providing a private setting conducive to interviewing children. No school district employee or school-allied volunteer will contact a parent or guardian regarding the interview of their student in child abuse or neglect referrals.

Investigators should be prepared to sign-in, show proper identification, and the appropriate agency-driven authorization or case number prior to accessing a student for an interview. A school representative may be present during interviews by caseworkers and/or law enforcement officials at the child's request or based on the age/maturity level of the child.

A child will not be detained beyond normal school hours, nor will the child be transported by the DFCS caseworker without the permission of the parent or legal guardian or an appropriate court authorization. If a child is removed from school by a DFCS caseworker or law enforcement officer, the child's parent or legal guardian will be notified by either DFCS or law enforcement. If the child's parent or legal guardian contacts the school, that person will be referred to DFCS or the appropriate law enforcement agency.

If the school is part of the ongoing treatment plan for the child, DFCS will keep the school informed about the subsequent findings and plans for the child and family. The goal is to share information and DFCI will be responsible for attempting to include the school in their treatment plan through case documentation.

g) <u>Special Response Situations</u>

i. Child Death or Near-Death Investigations

The investigation of child deaths or near-death investigations should include law enforcement, DFCS, and the District Attorney's Office. The agency first notified of the death or near-death incident should immediately contact the other agencies. Notification to DFCS should be made first to local DFCS staff as outlined in Appendix J—3 and then a referral can be filed with 855-GACHILD. Notification to the District Attorney's Office should be to the District Attorney, Chief Assistant District Attorney, Senior Investigator, or Child Fatality Review Chair as outlined in Appendix J—3.

ii. Domestic Violence

DFCS should be notified in all situations of domestic violence where children live in the home or where children are present. A determination must be made if the child is safe to remain in the home or remain with the current caregivers. If the parent(s) or custodial caregiver(s) are not capable of, or available to care for the child, DFCS should be notified immediately. DFCS should be notified and consulted before a child is placed with a non-custodial caregiver because DFCS must determine safe placement for the child. If no capable parent or caregiver is identified, the child should be placed into protective custody. The responding officer should ensure no children are being abused.

At the discretion of law enforcement, EMS may be called to the scene if there is any belief the child may be injured even though visible injuries are not noted. The law enforcement officer taking the arrest warrant is to include special conditions of bond prohibiting the offender's contact with the victim and any children of the victim, or with any children that were present. If the victim is a child, there should be a condition prohibiting contact with any child under the age of 18 years.

Responding officers should ensure that all witnesses and children are listed in the incident report.

If an arrest is made, a referral needs to be sent to DFCS by using the 855-GACHILD. If suspect has absconded, notify DFCS. If either caregiver who is a victim of domestic violence fails to protect the children from the offender, then steps should be taken to determine if the children need to be placed outside the home.

iii. Juvenile Offenders

Cases involving physical or sexual abuse between juveniles residing in the same residence or those who have ongoing or continued contact with victims pose a particular challenge. The goal of the protocol is to ensure the victim is safe and free from intimidation by establishing a process to quickly separate the offender and victim, to investigate whether the offender is also a victim, to provide services for both juvenile victims and juvenile offenders and their families, and to establish a process for early intervention. This protocol is not separate from the child abuse protocol and does not change how cases are reported or investigated.

1. Reporting

For complaints of juvenile offenders received by non-law enforcement agencies, the agency needs to notify DFCS and law enforcement immediately. Law enforcement must be notified in addition to DFCS because DFCS may by policy initially screen out sibling on sibling abuse when there is no allegation of parental/caregiver misconduct.

However, notification to county DFCS leadership as provided below should be made to provide opportunity for override and screen-in.

Brooke Ford - Director - 404 576 5107
Taylor Smithey - Program Director - 706 671 0464
Hailey Gagner - CPS Administrator - 470 859 7746

**If unable to reach, call intake and select the option for first responder/law enforcement to speak to on-call supervisor.

When a case is screened out, a notification will go to law enforcement, but that notification is not immediate and may take several days, which is the exact delay we seek to avoid.

2. Investigation and Removal of Offender

Upon receipt by law enforcement of a complaint of abuse by one juvenile upon another juvenile living in the same residence or those with ongoing or continued contact, law enforcement should take immediate steps to ensure the victim and other juveniles are separated from the juvenile offender. The goal is to keep the non-offending children safe and to protect them from abuse, intimidation, and harassment. The best scenario is to remove the offender and allow the victim to remain in the residence, however, the circumstances may not make that possible or appropriate. The following are the potential removal scenarios and expected protocol.

3. Cooperative Caregivers in Separating Juveniles

If the parents or caregivers are willing to cooperate and separate the children, gather information as to how the children will be separated and where the children will be located. Law enforcement needs to determine that the present caregivers and any potential caregivers are appropriate guardians and do not have a history of child abuse or abusive behaviors. Therefore, law enforcement should contact DFCS and have DFCS run a check through their system of the current caregivers and any individuals with whom the caregivers may place the offender. Law enforcement should run a criminal history check on the same individuals. If there is anything in the history that causes concern that the current caregivers or an identified potential caregiver is not an appropriate guardian, the child should not be placed with that individual.

If after hours, call 1-855-GA-CHILD for DFCS response.

4. Uncooperative or Unsupportive Caregivers in Separating Juveniles

If the parents or caregivers are uncooperative and do not wish to separate the children, or if the parents or caregivers are not supportive of the victim or disbelieving of the victim's disclosure, then consider taking protective custody of the victim and other non-offending children in the home. If at any time during the process, caregivers or parents become unsupportive of the victim, steps should be taken to locate supportive placement or remove the victim from the home, if necessary.

Before leaving the offending juvenile with the parents or caregivers, ensure the juvenile is safe to remain in the home by running a criminal history check and by contacting DFCS to run a check of their system.

If the parents/custodial caregivers have a history of child abuse or any sexual abuse, then a determination needs to be made by the responding agencies if any children are safe to remain in their custody.

5. Caregivers Lack Resources to Comply

If the parents or caregivers are unable to find another location for the offender, contact DFCS and make a neglect referral. Juveniles can be taken into protective custody due to neglect. If the juvenile offender is arrested as a juvenile, DJJ will be responsible for placement; otherwise, DFCS will be responsible for placement of the offender. Removal of victim should be the last option, but necessary if the only way to protect the child.

6. Removal of Offender by Arrest and Special Conditions of Bond

An arrest will temporarily remove the offender from the victim and other juveniles in the home.

Special conditions of bond or release should always be requested. Such special conditions of bond should include a provision for no direct or indirect contact with the victim; no unsupervised contact with any child under the age of 18 years; a condition to submit to a psycho-sexual evaluation within 14 days of release, sign all necessary releases for

DFCS and the prosecutor's office to communicate with the evaluator; and no access to the internet or possess any devices capable of accessing the internet.

If an offender is 17 years of age or younger and is released from custody pending resolution of the case, and the caregiver is unable to find a placement for the offender or is unwilling to find a placement for the offender, a neglect referral shall be made to DFCS by whatever agency is aware of the situation. Steps outlined above should be followed.

7. Early Intervention for Students Exhibiting Inappropriate Sexual Behavior at School

Any agency having information that a child is exhibiting inappropriate sexual behavior at school should report the incident to DFCS. The school should address the issue with the parents of the offender and should involve school counselors as necessary.

8. Determination of Whether the Juvenile Offender Has Been Victimized

Steps should be made to determine whether the juvenile offender is also a victim of abuse. If there is an allegation of abuse or facts suggesting abuse, the offender could be interviewed at the Child Advocacy Center, unless otherwise inappropriate. If the offender is under the age of 10 years, a forensic interview at the CAC may be most appropriate. The decision to interview an offending child at the CAC should be made in conjunction with CAC staff. If an offender is interviewed at the CAC, that child must be always supervised. If a forensic interview at the CAC is not appropriate, then a forensic interview should be obtained via a psychosexual evaluation.

9. Disposition

Prior to disposition of a juvenile offender's case, the juvenile should have a psychosexual evaluation. Such evaluation should be used when considering the disposition and treatment options.

10. Reintegration

Any reintegration of the juvenile offender and juvenile victim in the same living environment should be guided by the counselors treating each child.

iv. Commercial Sexual Exploitation of Children

1. Countywide Procedures

Commercial sexual exploitation of children (CSEC) presents unique challenges. The children are not only victims of sexual but often physical abuse. The nature of CSEC and its related criminal enterprises can place the child in the role of an offender. These children are first and foremost victims and should be treated as such by our agencies. Child victims of CSEC require special attention and protection; therefore, our protocol needs to be a system of rapid referrals to adequately address the needs of the child. To have an effective response, every attempt should be made to streamline the process by having a designated point person in each organization that is the "go-to" person for CSEC issues.

Each agency head should be familiar with the CSEC protocol.

When any agency suspects a child to be the victim of CSEC, or when a CSEC child is taken into custody, the following agencies should be notified IMMEDIATELY, and such notification should include the head of the agency:

- The reporting agency's head
- Law enforcement agency with jurisdiction
- The Office of the District Attorney
- DFCS. In most situations the CSEC child will be away from their home county/state and returning the child to their home might not be safe, or such determination may not be able to be made immediately. If the child is located in Cherokee County, our DFCS office will be involved even if the child is not a resident of our county.
- CSEC Response Team of CACGA at 1-866-END-HTGA

Physical examinations should be done at the Children's Healthcare of Atlanta's Stephanie V. Blank's Center for Safe and Healthy Children.

A forensic interview should be done by a trained professional at either the Anna Crawford Child Advocacy Center or the CHOA Center for Safe and Healthy Children. All agencies involved should be in the decision-making process on where to conduct the forensic interview.

CSEC cases should be staffed both through the local Cherokee County MDT and the CHOA CSEC MDT.

2. DFCS Procedure and Statewide Model

To set CSEC and Domestic Minor Sex Trafficking (DMST) apart from other forms of child abuse and exploitation, and to have clarity with regard to the range of incidents or situations to which DFCS policy is applicable, commercial sexual exploitation is defined as follows: sexual abuse/prostitution of a child by an adult or older juvenile involving payment in cash, food, shelter or other forms of value to the child or a third person; involving treatment of the child as a sexual and commercial object in activities such as prostitution, adult entertainment, pornography, and other forms of transactional sex where a child engages in sexual activities.

i. Initial Assessment

An initial assessment must carefully consider whether a possible victim of commercial sexual exploitation should be taken into care or placed back in the home.

Commonly, a child victim of commercial sexual exploitation may have run away from home on multiple occasions prior to being discovered as a victim. The child may be running away from mental, physical, and/or sexual abuse at home. A critical assessment is whether the parents and/or guardians were involved in any way in the commercial sexual exploitation of the child. Sometimes, a parent may have done everything they know how to do to protect the child but the child may continue to runaway to be with his or her “pimp” or “trafficker” due to the strong influence they have over the child.

All case managers should investigate the circumstances of the commercial sexual exploitation of the child and the child’s mental state carefully during the assessment phase of the case and well before making reunification plans with the parents and/or guardians.

Once there is sufficient information gained that the parents are not part of any sexual exploitation of the child, the case manager should then work closely with the parent and/or guardians in providing the appropriate CSEC/DMST specific resources to the child and family throughout the case.

However, a request by law enforcement for DFCS to not contact the parents for the safety of the child should be respected. Revealing confidential law enforcement investigatory information to possible suspects could easily place the child that has been recovered or other children that have yet to be recovered in danger. The Juvenile Court should be fully advised of this request when applying for court orders.

CPS staff/case managers should familiarize themselves the Indicators/Risk Factors found in Appendix E.

ii. Required Steps

Upon receipt of a report of suspected maltreatment involving a case where the child may be a victim of commercial sexual exploitation, CPS staff will immediately:

- Assess the safety of the child considering the physical and/or psychological indications that a child may be a victim of commercial sexual exploitation. (See Appendix E)
- Notify CACGA CSEC Response Team via:
    - Phone: 1-866-END-HTGA
    - Fax: 678-401-5955, or
    - Online referral form via their website: www.cacga.org/csec-response-team/

The CACGA CSEC Response Team manages a 24 hour a day 7 days a week hotline which provides information to potential victims, assistance to law enforcement seeking to rescue victims, and referrals for victim assistance.

Collaboration between DFCS and the CSEC Response Team is necessary to best address the needs of these children. The CSEC Response Team provides direct services for victims in the form of assessment, intensive case management, and advocacy. Referrals are recommended when there is a child in DFCS custody who has been arrested for prostitution.

iii. Medical Attention

The child should be brought to the local emergency room for medical evaluations for the health of the child. If the child is recovered within the metro-Atlanta area, the child should always be taken to the Children's Healthcare of Atlanta's Emergency Department. See Obtainment of a Forensic Medical Exam section.

iv. Forensic Interview

If the child is cooperative, attempt to coordinate a forensic interview of the child by a trained forensic interviewer as soon as practical. Staff must coordinate a CSEC/DMST specific forensic interview through local resources headed by the local Children's Advocacy Center if one is in your area. The child should not be subjected to multiple interviews with different parties whenever feasible as this will increase the trauma.

If the child is denying victimization, and/or is not cooperative, consider delaying the forensic interview until trust has been established with the child.

v. Local Law Enforcement

If the initial referral does not come from law enforcement, DFCS should always contact law enforcement within 24 hours and provide them with all information gathered from both intake and the initial investigation.

vi. Georgia Bureau of Investigation (GBI) Child Exploitation and Computer Crimes Unit

All case managers are to contact the GBI Child Exploitation and Computer Crimes Unit within 24 hours when a child is suspected of being a victim of commercial sexual exploitation or discovered in the course of involvement with DFCS.

The GBI has established the Child Exploitation and Computer Crimes Unit to specifically target Commercial Sexual Exploitation. Accordingly, case workers should contact a GBI Special Agent who can advise the caseworker on where to email any written documentation.

During regular business hours, call 404-270-8870 and ask for the Child Exploitation and Computer Crimes Unit Agent on call. On nights, weekends, and holidays, call the GBI communications center at 404-244-2600 or 1-800-282-8746 and ask for the on-call Child Exploitation and Computer Crimes agent.

vii. Intake Photos

When CSEC/DMST victim is recovered, there is a high likelihood that the child may runaway. Take a series of digital photos to assist law enforcement and the National Center for Missing and Exploited Children in locating the child. These photos should also be uploaded into SHINES.

viii. Family Support

Whatever stage the child's DFCS case is in, education surrounding the dynamics of CSEC/DMST must be provided to caregivers and foster parents, unless the parents or caregivers are involved in the exploitation. CSEC/DMST presents with unique challenges that caregivers must be made aware of to assist them in caring for the child.

While remaining in compliance with HIPAA, all pertinent information should be shared with the caregivers/foster parents. Family support should be coordinated through DFCS and the CACGA CSEC Response Team.

6. TREATMENT/COUNSELING

a) Treatment for Child Abuse Cases

For sexual and physical abuse cases staffed by the MDT, the MDT will determine if there is a need of referral for treatment. If a treatment referral is indicated, the Child Advocacy Center or other trained child therapist will provides therapy and counseling services. Many CACs utilize Trauma-Focused Cognitive Behavioral Therapy (TF-CBT).

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is widely regarded as the most effective treatment with sexually abused and traumatized children. This therapy emphasizes the importance of parent involvement. During therapy, therapists meet with the parent alone, the child alone, the parent and child together.

Therapy specifically helps children (and parents):

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

In addition to TF-CBT, some Child Advocacy Centers have therapists who have been specially trained in Play Therapy, a model of treatment and treatment techniques that emphasize utilization of the child's natural world—play—to facilitate healing. These techniques are often essential to treatment of abused children. Play therapists can use art, games, puppets, etc. and words to enable a child to communicate about, and heal from, their abuse experiences.

If there is not a local CAC, the primary-involved agency will provide the family with a list of local mental health providers known to have experience and expertise with child sexual and/or physical abuse. The primary-involved agency will provide additional assistance in selecting a provider based on the needs of the child, the financial resources of the family, and the availability of the provider. The provider should be a certified clinician trained and experienced in the treatment of child sexual abuse and trauma. For sexual exploitation cases, the CACGA CSEC Response Team should be contacted to assist in identification of appropriate service resources.

The referring agency will facilitate the acquisition of pertinent information regarding the case for the mental health provider treating the child. If, after beginning treatment, the family refuses further treatment or becomes uncooperative, or the mental health provider suspects that this lack of cooperation is endangering the child, a referral to DFCS will be made as with any case involving mandatory reporting.

When a state licensed clinician is not available, regional referrals should be provided.

Referrals for perpetrator treatment by state licensed clinicians will be coordinated by adult probation and parole for Superior and State court cases, and the Department of Juvenile Justice for Juvenile Court cases.

b) Reporting When a Child Discloses During Therapy

If a child discloses sexual abuse or severe physical abuse during psychotherapy or counseling, the mental health provider should NOT attempt a forensic interview. The provider should not attempt to question the child in detail about the alleged abuse or attempt to use anatomically correct dolls for investigative purposes. Instead, a referral to DFCS and law enforcement should be made immediately. The mental health provider should attempt to reassure the child and inform the child of the possibility of a forensic interview by a third party.

7. JUDICIAL PROCEDURES

a) Juvenile Court Dependency Proceedings

The Juvenile Court's purpose in dependency proceedings is to:

1. Assist and protect children whose physical or mental health and welfare is substantially at risk of harm from abuse, neglect, or exploitation and who may be further threatened by the conduct of others by providing for the resolution of dependency proceedings in juvenile court;
2. Ensure that dependency proceedings are conducted expeditiously to avoid delays in permanency plans for children;
3. Provide the greatest protection as promptly as possible for children; and
4. Ensure that the health, safety, and best interests of a child be the paramount concern in all dependency proceedings. O.C.G.A. §15-11-100

i. Dependent Child

A "dependent child" is a child who:

1. Has been abused or neglected and is in need of the protection of the court;
2. Has been placed for care or adoption in violation of law; or
3. Is without his or her parent, guardian, or legal custodian. O.C.G.A. §15-11-2 (22)

ii. Dependency Proceedings Time Frames—O C.G.A. § 15-11-102(b)

A preliminary protective hearing shall be held promptly and no later than 72 hours after a child is placed in foster care, provided that, if the 72-hour time frame expires on a weekend or legal holiday, such hearing shall be held on the next day which is not a weekend or legal holiday. O.C.G.A § 15-11-102(a).

If a child was not taken into protective custody or is released from foster care at a preliminary protective hearing, the following time frames apply:

1. A petition for dependency shall be filed within 30 days of the child's preliminary protective hearing;
2. Summons shall be served at least 72 hours before the dependency adjudication hearing;
3. The dependency adjudication hearing shall be held no later than 60 days after the filing of a petition for dependency; and
4. If the child's dispositional hearing is not held in conjunction with the dependency adjudication hearing, it shall be held and completed within 30 days after the conclusion of the dependency adjudication hearing.

If a child is not released from foster care at the preliminary protective hearing, the following time frames apply:

1. A petition for dependency shall be filed within 5 days of the preliminary protective hearing;
2. Summons shall be served at least 72 hours before the dependency adjudication hearing;
3. The dependency adjudication hearing shall be held no later than 10 days after the filing of a petition for dependency;
4. If a dispositional hearing is not held in conjunction with the dependency adjudication hearing, it shall be held and completed within 30 days after the conclusion of the dependency adjudication hearing.

iii. Findings for Removal—O.C.G.A. § 15-11-134

- Continuation in home contrary to welfare;
- Return to home contrary to welfare of the child;
- Reasonable efforts to avoid removal.

iv. Placement—O.C.G.A. § 15-11-135

Child taken into custody not placed in foster care prior to hearing unless:

- Foster care is required to protect child
- Child has no person able to supervise and care for child
- Court order for foster care
- No use of detention facilities for placement absent a delinquent act or adjudication that meets requirements for detention.

v. Reasonable Efforts—O.C.G.A. § 15-11-202

Reasonable Efforts Shall be Made to Preserve and Reunify Families:

- Prior to removal except as provided in O.C.G.A. §15-11-103;
- To eliminate the need for removal and to make it possible for child to return home safely at earliest possible time;
- With paramount concern being child's safety and health;
- Through appropriate services to child and family; and
- At every stage of the proceedings

Factors for Reasonable Efforts:

- Were the services offered relevant to safety and protection of child?
- Were services adequate to meet the needs of the child and family?
- Were the services culturally and linguistically appropriate?
- Were the services available and accessible?
- Were the services consistent and timely?
- Were the services realistic under the circumstances?

Reasonable Efforts Not Required- O.C.G.A. §15-11-203

- Not required where child subjected to aggravated circumstances
- Conviction for murder of another child of such parent
- Conviction of voluntary manslaughter of another child of such parent;
- Conviction for aiding, abetting, etc. to commit murder or involuntary manslaughter of child of such parent;
- Convicted of felony assault with serious bodily injury to child or another child of said parent;
- Convicted of rape, sodomy, aggravated sodomy, child molestation, aggravated child molestation, incest, sexual battery, aggravated sexual battery or child or another child of the parent;
- Registered as sex offender and preservation of parent-child relationship in not in child's best interests
- Rights to a sibling were involuntarily terminated and circumstances leading to termination have not resolved.

vi. Attorney Representation at Dependency Hearing—O.C.G.A. § 15-11-103

A child has a right to an attorney at all stages of juvenile court dependency proceedings. The court shall appoint an attorney for the alleged dependent child. The appointment shall be made as soon as practicable to ensure adequate representation of such child and in any event, before the first court hearing that may substantially affect the interests of such child.

vii. Protective Orders—O.C.G.A. § 15-11-29

The Juvenile Court may enter a protective order restraining or otherwise controlling the conduct of a person and the order may require any such person:

(1) To stay away from a person's home or a child;
(2) To permit a parent to visit his or her child at stated periods;
(3) To abstain from offensive conduct against a child, his or her parent, or any person to whom custody of such child is awarded;
(4) To give proper attention to the care of his or her home;
(5) To cooperate in good faith with an agency to which custody of a child is entrusted by the court or with an agency or association to which a child is referred by the court;
(6) To refrain from acts of commission or omission that tend to make a home not a proper place for a child;
(7) To ensure that a child attends school pursuant to any valid law relating to compulsory attendance;
(8) To participate with a child in any counseling or treatment deemed necessary after consideration of employment and other family needs; and
(9) To enter into and complete successfully a substance abuse program approved by the court.

After notice and opportunity for hearing afforded to a person subject to a protective order, a protective order may be modified or extended for a further specified period, or both, or may be terminated if the court finds that the best interests of the child and the public will be served thereby.

Protective orders may be enforced by citation to show cause for contempt of court by reason of any violation thereof and, where protection of the welfare of a child so requires, by the issuance of a warrant to take the alleged violator into custody and bring him or her before the court.

The Juvenile Court should consider such an order if the child abuse case has been or is about to be disposed of, and after the person against whom the protective order is sought has had due process, notice and opportunity to be heard.

If the protective order is not considered at the Disposition Hearing, where appropriate, DFCS, through its counsel, should apply for a protective order. DFCS counsel should request a hearing within ten days after the filing of the application for a protective order.

viii. Guardian Ad Litem and Court Appointed Special Advocate (CASA)

In addition to the attorney who represents the alleged dependent child, the Court shall also appoint a guardian ad litem (GAL). The child's attorney may serve as GAL unless or until a conflict of interest arises. The court shall appoint a CASA volunteer to serve as GAL whenever possible, and a CASA may be appointed in addition to an attorney serving as the child's guardian ad litem. O.C.G.A. § 15-11-104.

A CASA is a community volunteer who has been screened and trained regarding dependency, child development, and juvenile court procedures and has been appointed as a guardian ad litem by the court. The juvenile court judge has the authority to appoint a CASA volunteer at the earliest stage possible of Juvenile Court dependency proceedings to advocate for the best interest of abused and neglected children. In addition to the court's own motion, a request for CASA appointment can be made to the judge by the GAL, child's attorney, Citizen Review Panel member, DFCS case manager, SAAG, and any other interested party.

The locally operated affiliate CASA program is CASA Cherokee. CASA Cherokee is a program operated by The Children's Haven. The program operates alongside the Juvenile Court of Cherokee County. CASA Cherokee is responsible for recruiting, screening, training, and supervising local CASA volunteers. The Children's Haven has paid staff members that supervise the daily CASA program operations and provide volunteer supervision.

CASA Cherokee, a program of The Children's Haven, trains volunteers to advocate on behalf of children who have experienced abuse or neglect until they achieve permanency in a safe home.

a. Role of GAL/CASA Volunteer

The role of a CASA in juvenile court dependency proceedings shall be to advocate for the best interests of the child. O.C.G.A. §15-11-106. Pursuant to O.C.G.A. §15-11-105, in determining a child's best interests, a CASA as guardian ad litem shall consider and evaluate all of the factors affecting the best interests of a child in the context of a child's age and developmental needs. Such factors shall include:

1) The physical safety and welfare of such child, including food, shelter, health, and clothing;
2) The mental and physical health of all individuals involved;
3) Evidence of domestic violence in any current, past, or considered home for such child;
4) Such child's background and ties, including familial, cultural, and religious;
5) Such child's sense of attachments, including his or her sense of security and familiarity and continuity of affection for the child;
6) The least disruptive placement alternative for such child;
7) The child's wishes and long-term goals;
8) The child's community ties, including church, school, and friends;
9) The child's need for permanence, including his or her need for stability and continuity of relationships with a parent, siblings, and other relatives;
10) The uniqueness of every family and child;
11) The risks attendant to entering and being in substitute care;
12) The preferences of the persons available to care for such child; and
13) Any other factors considered by the guardian ad litem to be relevant and proper to his or her determination.

b. Responsibilities of GAL/CASA Volunteer—O.C.G.A. § 15-11-105(c)

Unless a child's circumstances render the following duties and responsibilities unreasonable, a CASA appointed as a guardian ad litem shall at a minimum:

1) Maintain regular and sufficient in-person contact with the child and, in a manner appropriate to his or her developmental level, meet with and interview such child prior to custody hearings, adjudication hearings, disposition hearings, judicial reviews, and any other hearings scheduled in accordance with the law;
2) In a manner appropriate to such child's developmental level, ascertain such child's needs, circumstances, and views;
3) Conduct an independent assessment to determine the facts and circumstances surrounding the case;
4) Consult with the child's attorney, if appointed separately, regarding the issues in the proceeding;
5) Communicate with health care, mental health care, and other professionals involved with such child's case;
6) Review case study and educational, medical, psychological, and other relevant reports relating to such child and the respondents;
7) Review all court related documents;
8) Attend all court hearings and other proceedings to advocate for such child's best interests;
9) Advocate for timely court hearings to obtain permanency for such child;
10) Protect the cultural needs of such child;
11) Contact the child prior to any proposed change in such child's placement;
12) Contact the child after changes in such child's placement;
13) Request a judicial citizen review panel or judicial review of the case;

14) Attend citizen panel review hearings concerning such child and if unable to attend the hearings, forward to the panel a letter setting forth such child's status during the period since the last citizen panel review and include an assessment of the DFCS permanency and treatment plans;
15) Provide written reports to the court and the parties on the child's best interests, including, but not limited to, recommendations regarding placement of such child, updates on such child's adjustment to placement, DFCS's and respondent's compliance with prior court orders and treatment plans, such child's degree of participation during visitations, and any other recommendations based on the best interests of the child;
16) When appropriate, encourage settlement and the use of any alternative forms of dispute resolution and participate in such processes to the extent permitted; and
17) Monitor compliance with the case plan and all court orders.

As a lay guardian ad litem, a CASA volunteer shall not engage in activities which could reasonably be construed as the practice of law.

Any information obtained in the CASA volunteer's assessment concerning unknown or unreported abuse shall be reported to the local DFCS office.

c. Confidentiality—O.C.G.A. § 15-11-105(e)(f)(g)

Upon presentation of an appointment order as guardian ad litem, a CASA shall have access to all records and information relevant to a child's case to which he or she is appointed when such records and information are not otherwise protected from disclosure.

GAL/CASA may not have access to any records or information that:

- Identifies a reporter of child abuse and/or any other person whose life or safety is likely to be endangered if their identity was not protected;
- Involves the disposition or treatment of a delinquent child within the Department of Juvenile Justice; and
- Concerns an investigation by the Office of the Child Advocate.

All records and information acquired, reviewed, or produced by a CASA volunteer during the course of his or her appointment shall be deemed confidential and shall not be disclosed except as ordered by the court.

Except as provided by O.C.G.A. § 49-5-41, any GAL or CASA volunteer who discloses confidential information obtained during his or her appointment shall be guilty of a misdemeanor.

b) Juvenile Court Delinquency Proceedings

Juvenile Court handles offenders under the age of 17 charged with delinquent offenses. The Superior Court shall initially have jurisdiction over any child between the age of 13 and 17 charged with rape, aggravated sodomy, aggravated child molestation, aggravated sexual battery, armed robbery if committed with a firearm, murder, voluntary manslaughter, murder in the second degree, aggravated assault if committed with a firearm upon a Public Safety Officer and aggravated battery upon a Public Safety Officer. By motion, the Superior Court can transfer the case to Juvenile Court. O.C.G.A § 15-11-560.

c) Magistrate Court

Magistrate Court is primarily involved in child abuse cases through the issuance of criminal warrants against perpetrators, the holding of preliminary commitment hearings, and in the setting bond and/or conditions of bail.

When a private individual files a civilian warrant application alleging any type of child abuse, the magistrate shall inquire as to the whereabouts of the child.

The magistrate shall then notify the appropriate police agency for investigation and further proceedings.

Child abuse victims do not need to appear at preliminary commitment hearings. Evidence of such abuse at a preliminary commitment or bond hearing shall be made by alternate means consistent with Georgia law.

Setting of bonds in child abuse cases shall be the responsibility of the Magistrate or Superior Court Judge as provided by law. In setting bond conditions, the magistrate should consider prohibiting contact between the child and the accused and contact between the accused and all children under the age of 18. A copy of the special conditions of bond should be provided to DFCS and Juvenile Court.

d) State Court

During a trial of criminal charges against a defendant in a child abuse case, State Court judges have a particular responsibility to ensure a fair and judicious process for all parties including the victim. Judges should ensure the child is protected during the trial by conducting proceedings in a manner both protective of the child and absent of perpetrator intimidation, consistent with the defendant's Constitutional rights. Care should be given to resolve these cases within a reasonable time after an accusation is filed.

Cases assigned to an Assistant Solicitor will be evaluated to determine whether sufficient evidence exists to accuse the alleged perpetrator. The Victim Assistance coordinator will notify DFCS and/or non-offending caregiver of services available to the child and family as well as any court dates or updates throughout the criminal process.

If a case proceeds to trial and the testimony of a child is required, care and attention will be provided to prevent the child from having contact with the offender prior to the child's testimony.

e) Superior Court

Superior Court may also issue warrants and set bonds in certain child abuse cases. As a consideration of bond/bail, the Superior Court Judge considers all the circumstances of the case paying particular attention to the safety of the child. The Judge hearing the bond motion should impose certain restrictive conditions of bond including, but not limited to, an order to have no contact with the alleged child victim or any other child prior to finalization of the case. All such conditions of bond should be communicated to DFCS and the Juvenile Court. In handling criminal cases and trials involving child abuse, Superior Court judges should:

- Ensure that the child is protected during the trial by conducting proceedings in a manner both protective of the child and absent of perpetrator intimidation, consistent with the defendant's Constitutional rights.
- Ensure that these cases are given priority on the trial calendar behind demand for trial and incarcerated defendants.
- Continuances should generally not be given except on legal grounds and the case should be rescheduled as promptly as possible. Every effort should be made to complete the trial as soon as possible.
- Every effort should be made to accommodate the witnesses contributing their time.
- Sentencing should reflect the need to protect the victim from the perpetrator and be consistent with the family case plan enacted in Juvenile Court. To this end, communication with the Juvenile Court should be maintained prior to sentencing to ensure a consistent approach in handling the family situation.

f) Prosecution

In Cherokee County, the District Attorney's Office is responsible for the prosecution of felony cases and the Solicitor-General's Office is responsible for the prosecution of misdemeanor cases. Both the District Attorney's Office and the Solicitor-General's Office provide great care to children who are victims of crime and involved in the prosecution of a case. Each office has a Victim Witness Program charged with protecting crime victim's rights set forth in the Georgia Crime Victims Bill of Rights.

Should a child be involved in a trial, all involved in the prosecution of the case will consider the sensitivity and needs of the child. Special accommodations will be made and communicated to the family to ensure the child is as comfortable as possible under the circumstances and is safe throughout their involvement.

The District Attorney's Office has a dedicated Special Victims Unit comprised of attorneys, investigators, and victim advocates responsible for prosecuting child abuse cases. The Special Victims Unit (SVU) works closely with law enforcement, DFCS, the Anna Crawford Children's Center, physicians, therapists, and other agencies involved in child abuse cases to ensure effective response, investigation, and prosecution of these cases.

SVU has victim advocates trained to notify families of the status of a criminal case and provide education about the court system to victims and witnesses in felony child abuse cases. SVU victim advocates offer victims and their families emotional support during the aftermath of crime and provide resources and insight into the complexity of the criminal justice system. Disposition of the case, whether by trial or by plea, is discussed with the victim's family and their input is considered prior to resolving the case.

The Special Victims Unit aims to coordinate, cooperate, and strengthen positive working relationships with all involved agencies to improve our response to child abuse and better serve the children in Cherokee County. The Special Victims Unit welcomes consultation with any agency at any stage of a child abuse investigation.

8. APPENDIX

A. CHILD ABUSE PROTOCOL STATUTE

O.C.G.A. § 19-12-2: Protocol committee on child abuse; written protocol; training of members; written sexual abuse and exploitation protocol

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(k) The protocol committee shall include a written sexual abuse and sexual exploitation section within its protocol which shall be filed with the Division of Family and Children Services of the Department of Human Services and the Office of the Child Advocate for the Protection of Children, a copy of which shall be furnished to each agency in the county handling the cases of sexually abused or exploited children. The sexual abuse and sexual exploitation section of the protocol shall outline in detail the procedures to be used in investigating and prosecuting cases arising from alleged sexual abuse and sexual exploitation and the procedures to be followed concerning the obtainment of and payment for sexual assault examinations. The sexual abuse and sexual exploitation section of the protocol shall be consistent with the policies and procedures of the Division of Family and Children Services of the Department of Human Services. The sexual abuse and sexual exploitation section of the protocol is not intended to, does not, and may not be relied upon to create any rights, substantive or procedural, enforceable at law by any party in any matter

civil or criminal. Such section of the protocol shall not limit or otherwise restrict a prosecuting attorney in the exercise of his or her discretion nor in the exercise of any otherwise lawful litigative prerogatives.

B. CHILD ABUSE PREVENTION

Child abuse is preventable; it is not inevitable.

Child abuse prevention rests on the principle that all children should have safe, stable, nurturing relationships and environments. Child abuse is not typically caused by a single factor, but rather is influenced by multiple complex factors related to the individual, family, community, and greater society. As such, it requires a public health approach involving the entire community to prevent and treat child abuse. Much progress has been made in understanding how to prevent child abuse and many common informal and everyday actions in addition to formalized evidence-based prevention focused programs all count towards prevention efforts. Fortunately, preventing child abuse can also help prevent other forms of violence and lead to healthier individuals and communities.

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

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

Mandated reporters play a critical role in recognizing when to help parents and children reach out for assistance and support before child abuse occurs. All mandated reporters should be trained in recognizing, reporting, and preventing maltreatment.

1. Risk factors for maltreatment

If potential risk factors for maltreatment are known, supports and services to mitigate those risks can be offered.

Family	Community
Parental or caregiver immaturity – very young or inexperienced parents many not understand a child's behaviors and needs and may not know what to expect at each stage of child development.	Drug endangered environment or neighborhood.
Unrealistic expectations of child's development.	Inadequate housing
Social isolation – a lack of family or friends to help with the demands of parenting	Underemployment & Unemployment
Frequent crises – stress related to finances, employment, relationships, etc.	Lack of access to medical care
Drug or alcohol problems	Residential turnover
Mental illness	Violent community

Dangerous home environments including exposure to drugs, weapons and dangerous objects or animals.	Lack of supportive resources

2. Protective factors for maltreatment

Everyone is exposed to risk at some point. Because risk cannot be eliminated entirely, it is important to build up protective factors, which can be built upon to increase family safety and well-being.

Family	Service Provider	Community
Develops close bonding with a child	Expresses positive expectations	Leaders prioritize community health, safety & quality of life for families
Those who are nurturing & protective	Encourages pro-social development	Engage supportive neighbors
Value & encourage education	Provides opportunities for leadership & participation	Develop neighborhood watch groups, mentoring groups
Manage stress	Staff view themselves as caring people	Ensure safe neighborhoods free from violence
Makes spending time with their children a priority	Support families when they recognize signs of stress or need	Provide supportive social & health networks
Seeks professional help when needed	Have family friendly information available which includes information on child development, bonding, & parenting	Have appropriate community resource referrals available

C. LOCAL, STATE, AND NATIONAL RESOURCES

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

1. **Cherokee County Resources**:
   - Umbrella agencies which plan, coordinate, and evaluate children and family programs and services
     - Cherokee Focus, 113 Palm St., Holly Springs, GA 30115, 770-345-5483
     - Georgia Hope, 104 Springfield Center Drive, Woodstock, GA, 706-279-0405
     - Cherokee County Local Interagency Planning Team (LIPT), 770-721,8503
     - Georgia Crisis & Access Line: 1-800-715-4225
     - ACE Community Support Service, 2205 Riverstone Blvd, Canton, GA, 770-704-0407
     - Highland Rivers, 191 Lamar Haley Pkwy, Canton, GA 30114, 770-704-1600
   - Training and community education around child abuse prevention and family support

- Prevent Child Abuse Cherokee, a program of The Children's Haven, 1083 Marietta Hwy, Canton, GA 30114, 770- 345-3274. Additionally, the Children's Haven has a staff member trained to provide support to individuals and agencies seeking resources through Find Help Georgia.
    - CASA Cherokee, a program of The Children's Haven, trains community volunteers to advocate on behalf of children who've experienced abuse or neglect until they achieve permanency in a safe home.
- Parent education programs, parent support groups, in-home parent education
    - Prevent Child Abuse Cherokee, a program of The Children's Haven, provides free in-home parent education and family support in English and Spanish; 1083 Marietta Hwy, Canton, GA 30114, 770-345-3274
    - Anna Crawford Children's Center (programs in Spanish, Portuguese, and in English), 9870 Highway 92 Ste 200, Woodstock, GA 30188; 678-504-6388
- After-school and summer programming
    - YMCA, 151 Waleska Street, Canton, GA 30114, 770-345-9622
    - Boys and Girls Club, 1082 Univeter Road, Canton, GA 30115, 770-720-7712
- Shelter for domestic violence victims and their families
    - Cherokee Family Violence Center 24/7 Crisis Hotline: 770-479-1703; En Español: 770-479-7050
- Alternative learning schools
    - Active Academies, 8871 Knox Bridge Highway, Canton, GA 30114, 770-721-6680
    - Mountain Education, 6500 Putnam Ford Rd., Woodstock, GA 30189, 470-863-4006
    - L.R. Tippens Education Center, 2450 Holly Springs Pkwy, Caton, GA 30115, 770-721-6450
- Community awareness information and events program
    - Safe Kids Cherokee County, 1130 Bluffs Parkway, Canton, GA 30114, 678-493-6290
- Sexual assault prevention education & crisis line
    - LiveSafe Resources 24-Hour Crisis Line 770-427-3390
- Child-friendly interview room
    - Anna Crawford Children's Center
- Sexual abuse awareness
    - Darkness to Light training through the Anna Crawford Children's Center

2. State Resources

- 2-1-1/United Way
    - 2-1-1: http://211online.unitedwayatlanta.org/
    - United Ways in Georgia: https://www.unitedway.org/local/united-states/georgia#
- Barton Child Law and Policy Center at Emory Law School, http://bartoncenter.net/
- Center of Excellence for Children's Behavioral Health, Georgia Health Policy Center, Georgia State University, https://gacoeonline.gsu.edu/, 404-413-0075
- Children's Advocacy Centers of Georgia (CACGA), https://www.cacga.org/, State CAC Network: 770-319-6888; Human Trafficking Concerns: 1-866-END-HTGA (842-4842)
- Children's Healthcare of Atlanta, Stephanie V. Blank Center for Safe and Healthy Children, https://www.choa.org/medical-services/child-protection-advocacy-center
- Committee on Justice for Children, Judicial Council of Georgia/Administrative Office of the Courts, https://georgiacourts.gov/j4c/; 404-656-5171
- Georgia Bureau of Investigation (GBI): https://gbi.georgia.gov/
    - 24 Hour Communications Center: 404-244-2600
    - Child Exploitation and Computer Crimes Unit: https://investigative-gbi.georgia.gov/investigative-offices-and-services/specialized-units/child-exploitation-and-computer-crimes-unit; 404-270-8870
    - Child Fatality Review: https://gbi.georgia.gov/CFR; 404-270-8715
    - Crisis Intervention Team: https://gbi.georgia.gov/divisions/crisis-intervention-team
    - Georgia Crime Information Center (GCIC) for attorneys requesting information for trial preparation: gcic.attorneys@gbi.state.ga.us; 404-244-2639
    - Sex Offender Registry: GCICSexOffenders@gbi.ga.gov; 404-270-8465
- Georgia Coalition Against Domestic Violence, https://gcadv.org; 404-209-0280
- Georgia Commission on Family Violence, https://gcfv.georgia.gov/; 404-657-3412, Hotline: 1-800-33-HAVEN (1-800-334-2836)
- Georgia Coroners Association, https://www.georgiacoronersassoc.org/

- Georgia Court Appointed Special Advocates (GA CASA), https://www.gacasa.org/; 800-251-4012, info@gacasa.org
- Georgia Criminal Justice Coordinating Council (CJCC), https://cjcc.georgia.gov/; 404-657-1956
- Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD); https://dbhdd.georgia.gov/; 404-657-2252
    - Georgia APEX Program (school-based mental health services and supports): https://dbhdd.georgia.gov/georgia-apex-program
    - Georgia Crisis and Access (GCAL) Line: 1-800-715-4225 (24/7)
    - Mental Health for Children, Young Adults, and Families: https://dbhdd.georgia.gov/be-dbhdd/be-supported/mental-health-children-young-adults-and-families
- Georgia Department of Community Affairs (DCA): https://www.dca.ga.gov/; 404-679-4840
- Georgia Department of Community Health (DCH): https://dch.georgia.gov/; 404-656-4507
- Georgia Department of Community Supervision: https://dcs.georgia.gov/; 678-783-4337
- Georgia Department of Early Care and Learning (DECAL), Bright from the Start: http://www.decal.ga.gov/; 404-656-5957
    - Childcare and Parent Services (CAPS) https://caps.decal.ga.gov/en/
- Georgia Department of Education (GaDOE): https://www.gadoe.org/Pages/Home.aspx
- Georgia Department of Juvenile Justice (DJJ): https://djj.georgia.gov/; 404-508-6500
- Georgia Department of Public Health (DPH)https://dph.georgia.gov/; 404-657-2700
    - Babies Can't Wait (Early identification, screening, and intervention for children 0-3 for developmental delays and certain health conditions): https://dph.georgia.gov/babies-cant-wait; 404-657-2850
    - Children 1st (Early intervention services for children 0-5 who may be at risk for poor health outcomes and developmental delays): https://dph.georgia.gov/children1st; 404-657-2850 Children's Health: https://dph.georgia.gov/childrens-health; 404-657-2850
    - Women, Infants, and Children (WIC): https://dph.georgia.gov/WIC; 800-228-9173
- Georgia Division of Family and Children Services (DFCS): www.dfcs.dhs.ga.gov; 1-855-GA-CHILD (1-855-422-4453)
    - Prevention and Community Support: https://dfcs.georgia.gov/services/prevention-and-community-support-section; gadfcs.prevention@dhs.ga.gov
- Georgia Early Education Alliance for Ready Students (GEEARS): https://geears.org/; 404-410-8564
- Georgia Family Connection Partnership: https://gafcp.org/; 404-527-7394
- Georgia Legal Services Program: https://www.glsp.org/; 1-800-498-9469
    - Atlanta Legal Aid: https://atlantalegalaid.org/
    - Georgia Legal Aid https://www.georgialegalaid.org/
- Georgia Office of the Attorney General; https://law.georgia.gov/; 404-651-8600
- Georgia Office of the Child Advocate: www.oca.ga.gov; 404-656-4200
- Georgia Governor's Office of Student Achievement (GOSA): https://gosa.georgia.gov/
- Georgia Vocational Rehabilitation Agency: https://gvs.georgia.gov/
- Get Georgia Reading Campaign for Grade Level Reading: https://getgeorgiareading.org/ ; GGR@gafcp.org
- Healthy Mothers, Healthy Babies: https://www.resourcehouse.com/hmhb/; 1-800-300-9003; thecoalition@hmhbga.org
    - Georgia Family Health Line (Help with finding services/referrals for medical care; interpreters available in 170+ languages): 1-800-300-9003
- Prevent Child Abuse Georgia (PCA GA): https://abuse.publichealth.gsu.edu/; 404-413-1296; 1-800-CHILDREN (1-800-244-5373)
- Prosecuting Attorneys' Council of Georgia: https://pacga.org/; 770-282-6300; info@pacga.org
- Technical College System of Georgia (TCSG): https://www.tcsg.edu/
- Together Georgia" https://togetherga.net/; 404-572-6170; office@togetherga.net
- University System of Georgia (USG): https://www.usg.edu/
- Voices for Georgia's Children: https://georgiavoices.org/

3. National Resources

- American Academy of Pediatrics: www.aap.org; 800-433-9016
- American Bar Association (ABA) Center on Children and the Law: https://www.americanbar.org/groups/public_interest/child_law/
- American Professional Society on the Abuse of Children (APSAC): https://www.apsac.org/; 877-402-7722
- Capacity Building Center for States: https://capacity.childwelfare.gov/states/

- Centers for Disease Control (CDC): https://www.cdc.gov/
- Child Abuse and Neglect Prevention: https://www.cdc.gov/violenceprevention/childabuseandneglect/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fviolenceprevention%2Fchildmaltreatment%2Findex.html
- Center for the Study of Social Policy: https://cssp.org/
- Child Welfare Information Gateway: https://www.childwelfare.gov/
- Children's Bureau, an Office of the Administration for Children and Families (ACF): https://www.acf.hhs.gov/cb
- Children's Defense Fund (CDF): https://www.childrensdefense.org/
- FRIENDS National Resource Center for Community-Based Child Abuse Prevention (CBCAP): https://friendsnrc.org/
- National Association of Counsel for Children (NACC): https://www.naccchildlaw.org
- National Association for Education of Young Children (NAEYC): https://www.naeyc.org/
- National Center for Children in Poverty: https://www.nccp.org/
- National Center for Missing and Exploited Children (NCMEC): https://www.missingkids.org/HOME; 1-800-THE-LOST (1-800-843-5678)
- National Center on Shaken Baby Syndrome: https://www.dontshake.org/; 801-447-9360; mail@dontshake.org
- National CASA/GAL Association: https://nationalcasagal.org/; 800-628-3233
- National Children's Advocacy Center: https://www.nationalcac.org/; 256-533-KIDS (5437)
- National Children's Alliance: https://www.nationalchildrensalliance.org/
- National Council on Child Abuse and Family Violence (NCCAFV): https://www.preventfamilyviolence.org/; 202-857-9778
- National Council of Juvenile and Family Court Judges (NCJFCJ): https://www.ncjfcj.org/
- National Domestic Violence Hotline: https://www.thehotline.org/; 1-800-799-SAFE (1-800-799-7233)
- National Fatherhood Initiative (NFI): https://www.fatherhood.org/
- National Institute of Health: https://www.nih.gov/
- National Safe to Sleep Public Education Campaign: https://safetosleep.nichd.nih.gov/
- Polaris Project: https://polarisproject.org/
- Prevent Child Abuse America: https://preventchildabuse.org/
- Prevention Institute: https://www.preventioninstitute.org/
- Period of PURPLE Crying: www.purplecrying.info
- Psychology Today: www.psychologytoday.com
- Rape, Abuse, and Incest National Network (RAINN): https://www.rainn.org/
- Zero to Three: https://www.zerotothree.org/

D. POSSIBLE INDICATORS[3] OF ABUSE[4]

All mandated reporters and protocol committee members should receive training in recognition, reporting and prevention of child abuse. The following factors, dynamics, and symptoms, while not exhaustive, may be indicative of abuse and serve as reminders for trained professionals. Free and reduced rate training is available in Georgia through a variety of providers. For more information about training contact: Office of the Child Advocate, 404-656-4200.

i. Physical Abuse

- Unexplained bruises or welts on the face, lips, mouth, torso, back, buttocks, thighs, or injuries in various stages of healing. The bruises may be in clusters or in patterns. They may appear on several different surface areas. May include bald patches on scalp.
- Unexplained fractures/dislocations to various parts of the body, including long bones, ribs, skull, nose, and/or facial structure or in various stages of healing. Fractures may also include multiple or spinal fractures.

[3] This list of indicators is not exhaustive. These indicators may suggest abuse but any one indicator or multiple indicators may not necessarily mean that a child has suffered abuse. Indicators should be considered as red flags necessitating further inquiry.

[4] Refer to CHOA training for more in-depth discussion and training of medical signs of abuse; contact CHOA at 404-785-5004 or cpctraining@choa.org for additional information.

- Unexplained burns from cigars or cigarettes, especially on palms, soles, back or buttocks. This may also include immersion burns (sock-like, glove-like, or doughnut shaped on buttocks or genitals). Infected burns may indicate a delay in seeking treatment.
- Unexplained missing or loosened teeth.
- Inadequate explanation of how injury sustained or explanation is otherwise inconsistent with actual type of injury.
- Child wears concealing clothing, regardless of weather.

ii. Neglect or Exploitation

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

iii. Factitious Disorder/Medical Child Abuse

- Unexplained seizures
- Life threatening events
- Chronic unexplained symptoms that resolve when child is protected
- Family history of similar sibling illnesses, unexplained sibling illness, or suspicious circumstances surrounding a death
- Discrepancies between history, clinical findings and general health of child
- Unusual signs and symptoms that do not fit clinical diagnosis
- Repeated hospitalizations and evaluations with definite medical diagnosis
- Caregiver welcomes invasive medical testing and displays considerable medical knowledge
- Family history of similar sibling illnesses, unexplained sibling illness, or suspicious circumstances surrounding a death
- Rare or unexplained lab findings
- Falsification of medical history
- Repeated requests for sexual abuse evaluations, especially if previously addressed or no other indication of sexual abuse
- Passive, abusive, or defensive spouse/partner
- "Doctor shopping"

iv. Endangering a Child

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

v. Sexual Abuse

- Difficulty walking or sitting
- Torn, stained, or bloody clothing
- Pain, discomfort, swelling, or itching in the genital area
- Pain upon urination
- Bruises, bleeding, or lacerations in the external genitals or anus area
- Poor sphincter control in previously toilet-trained child
- Vaginal or penile discharge of a sexually transmitted infection
- Victims may act out sexually or on younger children

- Self-harm
- Infantile behavior
- Parent/caregiver has extreme reaction to sex education or prevention education in the schools

vi. Sexual Exploitation

- Child frequently runs away
- Child is in possession of gifts/money, the origin of which is unknown
- Unexplained bruises or injuries
- New pattern of doing poorly in school or otherwise disengaged
- Sleeping in class
  Truancy and/or chronic absenteeism
- Gang involvement
- Changes in temperament/mood
- Withdrawn, uncommunicative, and/or isolated from family
- Not eating
- Little to no eye contact
- Substance use

vii. Emotional Abuse

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

E. INDICATORS AND RISK FACTORS FOR VICTIMS OF COMMERCIAL SEXUAL EXPLOITATION

a. Personal Indicators:

- Child has runaway from home and/or guardian three or more times within the last twelve months
- Inappropriate dress, including oversized clothing or overtly sexy clothing
- Poor personal hygiene
- Unexplained bruises or injuries
- Cigarette burns
- Child is in possession of large amounts of money
- Child is in possession of more than one cell phone
- Child is in possession of hotel keys
- Presence of "gifts" the origin of which is unknown
- Rumors among students regarding sexual activity, which victim may not necessarily deny
- Diagnosed with sexually transmitted disease (s)
- Older "boyfriend" close to 5 years older than the child or male friend or relative (who may or may not seem controlling)
- In the juvenile court system, probably on repeated status offenses particularly running away or truancy, shoplifting, or criminal trespass, giving false name or age to police
- New pattern of failing grades and/or school suspensions
- Not enrolled in school
- Fake identification and/or fake city issued permit to be an escort or dance in a strip club under another name or incorrect age.
- Substance abuse

- Gang clothing or other gang symbols
- Tattoo of someone's name or nickname, particularly on the back of the neck, or new tattoos in general
- Has a history of recruiting others into prostitution
- Arrest(s) of the child is in or around an area known for prostitution, such as an adult entertainment venue, strip club, massage parlor, X-rated video shop and/or hotel

b. Behavioral Indicators:
- Exhibits over-sexualized demeanor/behavior
- Angry, aggressive, clinically depressed, suicidal and/or tearful
- Fearful, anxious, depressed, submissive, tense, nervous
- Withdrawn, uncommunicative, and/or isolated from family
- Little to no eye contact
- Truancy and/or chronic absenteeism
- Sleeping in class
- Not eating

c. Family Indicators:
- Runaway child
- Lack of adult supervision/support
- Sexual or physical abuse at home, by family member or friend
- History with DFCS
- Parental substance abuse
- Parental history of prostitution arrests
- Domestic violence
- Living, hanging out in geographic areas known to be a gathering place for prostitution

F. FAMILY VIOLENCE

Laws have been enacted to protect children living in homes with family violence. Children who live with domestic violence face numerous risks, such as the risk of exposure to traumatic events, the risk of neglect, the risk of being directly abused, and the risk of losing one or both of their parents. All of these can lead to negative outcomes for children and clearly have an impact on them. Research studies consistently have found the presence of three categories of childhood problems associated with exposure to domestic violence:

1. Behavioral, social, and emotional problems—higher levels of aggression, anger, hostility, oppositional behavior, and disobedience; fear, anxiety, withdrawal, and depression; poor peer, sibling, and social relationships; low self-esteem.
2. Cognitive and attitudinal problems—lower cognitive functioning, poor school performance, lack of conflict resolution skills, limited problem-solving skills, acceptance of violent behaviors and attitudes, belief in rigid gender stereotypes and male privilege.
3. Long-term problems—higher levels of adult depression and trauma symptoms, increased tolerance for and use of violence in adult relationships.

"Family violence" under O.C.G.A. §19-13-1: means the occurrence of one or more of the following acts between past or present spouses, persons who are parents of the same child, parents and children, stepparents and stepchildren, foster parents and foster children, or other persons living or formerly living in the same household:

(1) Any felony; or (2) Commission of offenses of battery, simple battery, simple assault, assault, stalking, criminal damage to property, unlawful restraint, or criminal trespass.

The term "family violence" shall not be deemed to include reasonable discipline administered by a parent to a child in the form of corporal punishment, restraint, or detention.

G. CRIMES AGAINST CHILDREN

Offense	O.C.G.A	Elements	Sentencing Range
Rape	§ 16-6-1	**1.** carnal knowledge **2.** of a female **3.** forcibly and against her will – Carnal knowledge= any penetration of the female sex organ by the male sex organ	25-life subject to 17-10-6.1*
Rape (under 10)	§ 16-6-1	**1.** carnal knowledge **2.** of a female **3.** less than 10 years of age	25-life subject to 17-10-6.1*
Aggravated Sodomy	§ 16-6-2	**1.** sodomy (sex organ of one and mouth or anus of another) **2.** with force and against the will of another	25-life subject to 17-10-6.1*
Aggravated Sodomy (under 10)	§ 16-6-2	**1.** sodomy (sex organ of one and mouth or anus of another) **2.** with a person **3.** less than 10 years of age	25-life subject to 17-10-6.1*
Statutory Rape	§ 16-6-3	**1.** sexual intercourse **2.** with any person **3.** under 16	1-20 years if 21 years or older, 10-20 years subject to 17-10-6.2 if V is 14 or 15, and Δ is 18 or younger, + no more than 4 years older than V, misdemeanor
Child Molestation	§ 16-6-4	**1.** immoral or indecent act **2.** to, in the presence of, or with **3.** any child under 16 **4.** with the intent to arouse or satisfy the sexual desires of either the child or the person – the touching of each area shall constitute a separate offense of child molestation	5-20 years subject to 17-10-6.2* 2nd or subsequent: 10, 30, or life if V is 14 or 15, and Δ is 18 or younger, + no more than 4 years older than V, misdemeanor
Aggravated Child Molestation	§ 16-6-4	**1.** an act of child molestation **2.** which physically injures the child -OR- 1. an act of child molestation 2. which involves an act of sodomy (sex organ of one and mouth or anus of another)	25-life subject to 17-10-6.1* if sodomy: if V is 13, 14, or 15, and Δ is 18 or younger, + no more than 4 years older than V, misdemeanor
Enticing a Child for Indecent Purposes	§ 16-6-5	1. solicits, entices, or takes 2. a child under 16 3. to any place whatsoever 4. for the purpose of child molestation or indecent acts	10-30 years subject to 17-10-6.2* if V is 14 or 15, and Δ is 18 or younger, + no more than 4 years older than V, misdemeanor
Improper Sexual Contact by Employee or Agent	§ 16-6-5.1	1st Degree: **1.** employee or agent **2.** knowingly engages in **3.** sexually explicit conduct **4.** with another person whom such employee or agent knows is contemporaneously: **i.** enrolled as a student at a school of which he or she is an employee or agent **ii.** under probation, parole, a program or within a facility as a condition of probation or parole, accountability court, or pretrial supervision of which he or she is an employee or agent	1st degree: 1-25 years and fine not to exceed $100,000 if child is under 16: 10-30 years, and fine not to exceed $100,000, and subject to 17-10-6.2 if child is at least 14 but less than 21, and Δ is 21 or younger, + no more than 48 months older than V, misdemeanor if child is under 16 and act physically injures the victim or

		iii. being detained by or is in the custody of any law enforcement agency of which he or she is an employee or agent **iv.** patient in or at a hospital of which he or she is an employee or agent **v.** in the custody of a correctional facility, juvenile detention facility, facility providing services to disabled person, or facility providing child welfare/youth services of which he or she is an employee or agent **vi.** the subject of such employee or agent's actual or purported psychotherapy treatment or counseling, or **vii.** admitted for care at a sensitive care facility of which he or she is an employee or agent – *Sexually Explicit Conduct* defined: o Sexual intercourse o Bestiality o Masturbation o Lewd exhibition of the genitals or pubic area o Flagellation or torture by or upon a nude person o Fettered, bound, or otherwise physically restrained on the part of a nude person o Physical contact in an apparent act of sexual stimulation or gratification with any person's unclothed genitals, pubic area, buttocks, or female's nude breasts o Defecation or urination for purpose of sexual stimulation of viewer o Penetration of vagina or rectum by any object (except medical procedure) **1)** 2nd Degree: – same elements as 1st degree, except replace sexually explicit conduct with sexual contact – *Sexual Contact* defined: o Any contact involving the intimate parts of either person for the purpose of sexual gratification of either person – Consent of V is not a defense	involves an act of sodomy: 25-50 years, and a fine not to exceed $100,000, and subject to 17-10-6.2 2nd degree: misdemeanor, high and aggravated if child under 16: 5-25 years and fine not to exceed $25,000, subject to 17-10-6.2 if child is at least 14 but less than 21, and Δ is 21 or younger, + no more than 48 months older than V, misdemeanor
Improper Sexual Contact by Foster Parent	§ 16-6-5.1	**1.** being a foster parent **2.** knowingly engages **3.** in sexually explicit conduct **4.** with his or her current foster child Same distinction between 1st and 2nd degree, as it relates to sexually explicit conduct and sexual contact Same definitions of sexually explicit conduct and sexual contact – Consent of V is not a defense	1st degree: 1-25 years and fine not to exceed $100,000 if child is under 16: 10-30 years, and fine not to exceed $100,000, and subject to 17-10-6.2 if child is at least 14 but less than 21, and Δ is 21 or younger, + no more than 48 months older than V, misdemeanor if child is under 16 and act physically injures the victim or involves an act of sodomy: 25-50 years, and a fine not to exceed $100,000, and subject to 17-10-6.2 2nd degree: misdemeanor, high and aggravated if child under 16: 5-25 years and fine not to exceed $25,000, subject to 17-10-6.2

			if child is at least 14 but less than 21, and Δ is 21 or younger, + no more than 48 months older than V, misdemeanor
Incest	§ 16-6-22	**1.** sexual intercourse <u>OR</u> sodomy (sex organs of one and mouth or anus of another) **2.** with a person he or she knows they are related to by blood or marriage as follows: **a.** father + child/stepchild **b.** mother + child/stepchild **c.** siblings of whole or half blood **d.** grandparent + grandchild of whole or half blood **e.** aunt +niece/nephew of whole or half blood **f.** uncle + niece/nephew of whole or half blood	10-30 years if child under 14: 25-50 years subject to 17-10-6.2*
Sexual Battery	§ 16-6-22.1	**1.** intentionally makes **2.** physical contact **3.** with intimate parts of another **4.** without consent – *Intimate Parts* defined as: primary genital area, anus, groin, inner thighs, or buttocks of male or female, and the breasts of a female	Misdemeanor: high and aggravated
Sexual Battery Against a Child Under 16	§ 16-6-22.1	**1.** intentionally makes **2.** physical contact **3.** with intimate parts of another **4.** without consent **5.** against any child under the age of 16 – *Intimate Parts* defined as: primary genital area, anus, groin, inner thighs, or buttocks of male or female, and the breasts of a female	1-5 years 2nd or subsequent misd. sexual battery: 1-5 years and subject to 17-10-6.2*
Aggravated Sexual Battery	§ 16-6-22.2	**1.** intentionally penetrates **2.** with a foreign object **3.** the sexual organ OR anus of another **4.** without consent OR V is under 16, and the conduct is for the purpose of sexual arousal on the part of the offender or V	25-life subject to 17-10-6.1*
Solicitation of Sodomy (under 18)	§ 16-6-15	**1.** solicits **2.** a person under 18 **3.** to perform or submit **4.** to an act of sodomy **5.** for money	5-20 years
Sexual Exploitation of Children (possession) *(of child sexual abuse material)*	§ 16-12-100(b)(8)	**1.** knowingly **2.** possess or control **3.** a material which depicts a minor or portion of a minor's body **4.** engaged in **5.** any sexually explicit conduct *Same definition of *sexually explicit conduct* for each section in § 16-12-100 *Sexually Explicit Conduct* defined: – Sexual intercourse – Bestiality – Masturbation – Lewd exhibition of the genitals or pubic area – Flagellation or torture by or upon a nude person – Fettered, bound, or otherwise physically restrained on the part of a nude person – Physical contact in an apparent act of sexual stimulation or gratification with any person's unclothed genitals, pubic area, buttocks, or female's nude breasts – Defecation or urination for purpose of sexual stimulation of viewer	5-20 years subject to 17-10-6.2*

		– Penetration of vagina or rectum by any object (except medical procedure)	
Sexual Exploitation of Children (induce, entice, coerce) *(pertaining to child sexual abuse material)*	§ 16-12-100(b)(1)	**1.** knowingly **2.** employ, use, persuade, induce, entice, or coerce **3.** any minor (under 18) **4.** to engage in (or assist any other person to engage in) **5.** any sexually explicit conduct **6.** for the purpose of producing any visual medium depicting such conduct **Same definition of *sexually explicit conduct* for each section of § 16-12-100	5-20 years subject to 17-10-6.2*
Sexual Exploitation of Children (distribute, possess with intent to distribute) *(pertaining to child sexual abuse material)*	§ 16-12-100(b)(5)	**1.** knowingly **2.** create, reproduce, publish, promote, sell, distribute, give, exhibit, or possess with intent to sell or distribute **3.** a visual medium **4.** which depicts a minor (or portion of minor's body) **5.** engaged in **6.** any sexually explicit conduct **Same definition of *sexually explicit conduct* for each section of § 16-12-100	5-20 years subject to 17-10-6.2*
Computer Pornography *(commonly used for chat/ undercover operation case)*	§ 16-12-100.2(d)(1)	**1.** intentionally or willfully **2.** utilize **3.** a computer wireless service or Internet service, or other electronic device **4.** to seduce, solicit, lure, or entice **5.** a child, or another person believed by the offender to be a child **6.** to commit any illegal act by, with, or against a child **7.** relating to the offense of aggravated sodomy, aggravated child molestation, or child molestation, enticing a child for indecent purposes, or public indecency, or any conduct that by its nature is an unlawful sexual offense against a child	1-20 years if V 14 and Δ 18 or younger, misdemeanor Not eligible for First Offender (§42-8-60)
Obscene Internet Contact with Children *(commonly used for chat/ undercover operation case)*	§ 16-12-100.2(e)(1)	**1.** has contact that involves any matter containing explicit verbal descriptions or narrative accounts **2.** with someone he knows to be a child or with someone he believes to be a child **3.** via a computer wireless service or Internet service, or other electronic device **4.** of sexually explicit nudity, sexual conduct, sexual excitement, or sadomasochistic abuse **5.** with the intent to arouse or satisfy the sexual desires of accused or the child	1-10 years if V 14 and Δ 18 or younger, misdemeanor Not eligible for First Offender (§42-8-60)
Cruelty to Children	§ 16-5-70	1st degree: **1.** A parent, guardian, or other person supervising the welfare of or having immediate charge or custody **2.** Of a child under the age of 18 **3.** *willfully deprives* the child of necessary sustenance to the extent that the child's health or well-being is jeopardized. OR **4.** *maliciously causes* **5.** a child under the age of 18 **6.** cruel or excessive physical or mental pain 2nd degree: **1.** a person with *criminal negligence* causes **2.** a child under the age of 18 **3.** cruel or excessive physical or mental pain. 3rd degree: **1.** Such person, who is the primary aggressor, **2.** intentionally allows **3.** a child under the age of 18 **4.** to witness the commission of a forcible felony, battery* or family violence battery*;	1st degree: 1-20 2nd degree: 1-10 3rd degree: misdemeanor

		OR has knowledge that a child under the age of 18 is present and sees or hears the act, commits a forcible felony, battery, or family violence battery. *O.C.G.A. 16-5-23.1, A person commits the offense of battery when he or she intentionally causes substantial physical harm or visible bodily harm to another. The term "visible bodily harm" means bodily harm capable of being perceived by a person other than the victim and may include, but is not limited to, substantially blackened eyes, substantially swollen lips or other facial or body parts, or substantial bruises to body parts. If the offense of battery is committed between past or present spouses, persons who are parents of the same child, parents and children, stepparents and stepchildren, foster parents and foster children, or other persons living or formerly living in the same household, then such offense shall constitute the offense of family violence battery. In no event shall this subsection be applicable to reasonable corporal punishment administered by parent to child.	

H. MEDICAL PERSONNEL

a) Response

a. Sexual Abuse:

i. Recent Sexual Contact (within 72 hours and up to 120 hours)

1. Identify and manage acute medical problems.
2. If child presents to the Emergency Room, obtain a medical history to identify possible sexual contact. (Information is taken only as necessary for medical treatment.)
3. Notify DFCS and law enforcement.
4. Arrange for a formal specialized medical evaluation to be conducted at an appropriate location.
5. Conduct testing and treatment for sexually transmitted diseases and pregnancy as necessary.
6. Make a referral for a Mental Health assessment and evaluation if needed.
7. Facilitate the scheduling of a follow-up appointment by DFCS or the patient; the information shall be forwarded to the primary care physician.
8. Send a written report is to DFCS and law enforcement with expert medical opinion clearly stated. Forensic interviews should occur at the Children's Advocacy Center or designated equipped location (for children 17 years or younger) according to Protocol guidelines.

ii. Sexual Abuse at remote time (> 120 hours)

1. Complete medical interview to confirm sexual contact (detailed questioning to be reserved for investigative interview).
2. Evaluate and treat acute medical problems.
3. Make a mental health referral if appropriate.
4. Notify DFCS and law enforcement.
5. Support the making of a referral for medical evaluation by DFCS.
6. Send a copy of Emergency Room evaluation to follow-up physician.

iii. Medical condition suspicious for sexual abuse (bleeding or infection)

1. Conduct thorough physical and laboratory examination of the patient. (Sexual assault kit is utilized as deemed necessary).
2. Treat any injuries and/or illnesses.
3. Notify DFCS and law enforcement.
4. Refer the child to abuse specialist for a specialized medical evaluation as necessary.
5. Send a copy of Emergency Room Report to follow-up physician.
6. Send written report to DFCS, with expert medical opinion clearly stated on report.

iv. Suspected sexual exploitation

1. Notify security if the child has been brought in by someone who appears to be his or her pimp/trafficker.
2. Identify and manage acute medical problems
3. Conduct thorough physical and laboratory examination of the child. including drug testing or sexual assault kit, as appropriate.
4. Send copy of emergency record to follow-up physician.
5. Notify DFCS and law enforcement.

b. Physical Abuse
   i. Take a thorough history of the injury separately from each person with the child.
   ii. If the history is of abusive treatment or the injury does not match the history, make a diagnosis of suspected child abuse is made and notify DFCS and law enforcement.
   iii. Fully document injuries in writing.
   iv. Take photos of injuries. (Photography is essential. Equipment should be purchased by the team).
   v. Obtain imaging studies (for example, complete skeletal survey, head and/or abdominal CT) and lab studies as appropriate.
   vi. Provide any necessary medical care.
   vii. Send copy of emergency record to the follow-up physician.
   viii. Consult Primary Care Physician or the Pediatrician on call. If available, a child abuse expert pediatrician is preferred.
   ix. Send written report to DFCS, with expert medical opinion clearly stated on the report.
   x. Support DFCS' efforts to arrange for examination of siblings

c. Neglect:
   i. Failure to thrive
      1. Take complete history and conduct full physical examination.
      2. Review all available medical records.
      3. Notify DFCS.
      4. Facilitate DFCS' efforts to schedule a follow-up appointment if there is no consistent medical care provider.
      5. Support arrangements made for examination of siblings by follow-up physician.
      6. Develop short and long-term treatment plan.
   ii. Other Neglect issues
      1. Take complete medical history and conduct full physical examination.
      2. Review all available medical records.
      3. Notify DFCS.
      4. Support DFCS' efforts to arrange medical follow-up.
      5. For cases of severe neglect, consider referral to child abuse specialist for complete review (to include medical review, scene photos, DFCS and Law enforcement records).

d. Factitious Disorder/Medical Abuse
   i. Factitious disorder is a medical diagnoses and can only be made by a licensed physician.
   ii. Intake reports made to any agency will be referred to the Multi-Disciplinary Team for multidisciplinary intervention in coordination with medical personnel. A pediatric expert in medical abuse should be consulted.
   iii. DFCS, medical personnel, and the MDT will consider whether notification of the parents poses a danger to the child. In general, routine notification of the parent that an investigation is in process is dangerous to the child until such time as the case is decided.
   iv. A plan of action for each agency represented will be coordinated through the MDT. A plan of action may include the following tasks:
      1. Review all of child's available medical records
      2. Obtain verification of as many items as possible (records of drugs purchased, blood levels on child)
      3. Seek report of child's condition when parent is absent
      4. If appropriate, video monitoring in hospital with plan in place to intervene if child is found to be in danger from perpetrator's actions
      5. A plan of action may include the following task: Follow-up protection plan by DFCS and Law Enforcement and legal actions as dictated by evidence.

b) Emergency Custody by a Physician

O.C.G.A. § 15-11-131. Temporary protective custody of child by physician without court order and without parental consent; immunity

(a) Notwithstanding Code Section 15-11-133, a physician licensed to practice medicine in this state who is treating a child may take or retain temporary protective custody of such child, without a court order and without the consent of his or her parent, guardian, or legal custodian, provided that:

(1) A physician has reasonable cause to believe that such child is in a circumstance or condition that presents an imminent danger to such child's life or health as a result of suspected abuse or neglect; or

(2) There is reasonable cause to believe that such child has been abused or neglected and there is not sufficient time for a court order to be obtained for temporary custody of such child before such child may be removed from the presence of the physician.

(b) A physician holding a child in temporary protective custody shall:

(1) Make reasonable and diligent efforts to inform the child's parents, guardian, or legal custodian of the whereabouts of such child;

(2) As soon as possible, make a report of the suspected abuse or neglect which caused him or her to take temporary custody of the child and inform DFCS that such child has been held in temporary custody; and

(3) Not later than 24 hours after such child is held in temporary custody:

(A) Contact a juvenile court intake officer, and inform such intake officer that such child is in imminent danger to his or her life or health as a result of suspected abuse or neglect; or

(B) Contact a law enforcement officer who shall take such child and promptly bring such child before a juvenile court intake officer.

(c) A child who meets the requirements for inpatient admission shall be retained in a hospital or institution until such time as such child is medically ready for discharge. Upon notification by the hospital or institution to DFCS that a child who is not eligible for inpatient admission or who is medically ready for discharge has been taken into custody by a physician and such child has been placed in DFCS custody, DFCS shall take physical custody of such child within six hours of being notified.

(d) If a juvenile court intake officer determines that a child is to be placed in foster care and the court orders that such child be placed in DFCS custody, then:

(1) If such child remains in the physical care of the physician, DFCS shall take physical possession of such child within six hours of being notified by the physician, unless such child meets the criteria for admission to a hospital or other medical institution or facility; or

(2) If such child has been brought before the court by a law enforcement officer, DFCS shall promptly take physical possession of such child.

(e) If a juvenile court intake officer determines that a child should not be placed in foster care, such child shall be released.

(f) If a child is placed in foster care, then the court shall notify such child's parents, guardian, or legal custodian, the physician, and DFCS of the preliminary protective hearing which is to be held within 72 hours.

(g) If after the preliminary protective hearing a child is not released, DFCS shall file a petition alleging dependency in accordance with this article, provided that there is a continued belief that such child's life or health is in danger as a result of suspected abuse or neglect.

(h) Any hospital or physician authorized and acting in good faith and in accordance with acceptable medical practice in the treatment of a child under this Code section shall have immunity from any liability, civil or criminal, that might otherwise be incurred or imposed as a result of taking or failing to take any action pursuant to this Code section. This Code section shall not be construed as imposing any additional duty not already otherwise imposed by law.

I. PROTECTIVE CUSTODY; REMOVAL OF A CHILD FROM THE HOME

O.C.G.A. § 15-11-133: Removal of child from the home; protective custody

(a) A child may be removed from his or her home, without the consent of his or her parents, guardian, or legal custodian:

(1) Pursuant to an order of the court under this article; or

(2) By a law enforcement officer or duly authorized officer of the court if:

(A) A child is in imminent danger of abuse or neglect if he or she remains in the home; or

(B) A child is a victim of trafficking for labor or sexual servitude under Code Section 16-5-46.

(b) Upon removing a child from his or her home, a law enforcement officer or duly authorized officer of the court shall:

(1) Immediately deliver such child to a medical facility if such child is believed to suffer from a serious physical condition or illness which requires prompt treatment, and, upon delivery, shall promptly contact DFCS;

(2) Bring such child immediately before the juvenile court or promptly contact the juvenile court; and

(3) Promptly give notice to the court and such child's parents, guardian, or legal custodian that such child is in protective custody, together with a statement of the reasons for taking such child into protective custody.

(c) The removal of a child from his or her home by a law enforcement officer shall not be deemed an arrest.

(d) A law enforcement officer removing a child from his or her home has all the privileges and immunities of a law enforcement officer making an arrest.

(e) A law enforcement officer shall promptly contact the juvenile court for issuance of a court order once such officer has taken a child into protective custody and delivered such child to a medical facility.

(f) The juvenile court shall immediately determine if a child should be released, remain in protective custody, or be brought before the court upon being contacted by a law enforcement officer, duly authorized officer of the court, or DFCS that a child has been taken into protective custody.

(g) In addition to the requirements of Code Section 15-11-134, prior to authorizing the removal of a child from his or her home as provided in paragraph (1) of subsection (a) of this Code section or ordering a child to remain in protective custody as provided in subsection (f) of this Code section, the court shall consider whether there are reasonable alternatives to the removal of the child and placement of the child in foster care and may order temporary alternatives to foster care in lieu of removing the child and placing the child in protective custody or continuing the child in protective custody pursuant to Code Section 15-11-133.1.

J. CHEROKEE COUNTY CHILD FATALITY REVIEW (CFR)

1) CFR Protocol

a) Organization
  a. Structure: The Child Fatality Committee (CFR) previously established by law for each of the State's 159 counties has the responsibility for conducting fatality reviews.
  b. Membership
    i. Committee statutorily mandated members include:
      - Coroner
      - District attorney
      - Department of family and children services
      - Juvenile court
      - Public health
      - County mental health
      - Law enforcement

b) Membership Duties
  a. Chairman's Role
    - Accept report and notification from the Coroner's Office about the death of a child.
    - Accept verbal report from Law Enforcement at the time of incident and refer for autopsy.
    - Determine from the available resources, and according to the committee's criteria, of the cases to be reviewed by the committee.
    - Distribute the list of cases to be reviewed to' the Committee' members.
    - Arrange to have the necessary information from investigative reports, medical records, autopsy reports or other items made available to committee members.
    - Schedule and notify the members of an upcoming review meeting.

- Serve as a liaison with each local agency, with other Child Abuse Protocol Committees and the State Fatality Review Panel.
- Chair the meeting of the committee.
- Ensure that all State Fatality Review Panel reporting and data collection requirements are met including reports being forwarded the District Attorney and the State Fatality Review Panel.
- Oversee overall adherence to the committee review process

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

c. Medical Examiner/Coroner
- Liaison with the committee.
- Assist in legal issues.

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

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

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

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

h. Education
    - Provide input about significant school records on deceased or siblings.
    - Liaison with school personnel or resources for the family.
    - Liaison with school personnel about their concerns about childhood death
i. Citizen Advocate
    - Serve as a liaison with community groups.
    - Assist with location of resources for prevention and intervention.
    - Act as an impartial participant representing the child, rather than any one government agency responsible for handling the case.
j. Others
    - Regular members to be added may include pathologist, probation, parole, domestic violence, preschool, military, researcher.
    - Occasional members may include professionals and others that have a primary role with a given case, such as local law enforcement not on the committee but managing the case.

c) Activating the Review Process
    a. Coroner
        i. The Coroner shall notify the Chairperson of the death as soon as possible after he becomes aware of the situation.
        ii. The Coroner shall forthwith without delay submit a copy of an Autopsy within 48 hours of receiving said autopsy to the Chairperson of the Child Fatality Review Committee.
        iii. Committee members must be notified of specific case identifiers by the medical examiner/Coroner including name, address, date of birth, etc., so that they can look for pervious records.
    b. Law Enforcement
        i. Law Enforcement will contact the Office of the District Attorney's Chief Investigator, the Child Fatality Chairperson, or the District Attorney, no matter the time of discovery of incident.

d) The First 72 Hours: Initiating the Investigation
    a. Within 72 hours of notification of a child death, the CFR Chairperson will e-mail to all committee members all information obtained as of that time as to the specifics of the child's death.
    b. The committee members will use the information contained in the report to determine if their agency has had any prior contact with the child and/or the child's family.

e) The First 30 Days
    a. The CFR Committee will meet within 30 days of notification of the child's death.
    b. Agencies that discover records on the case should notify the Chairperson as soon as possible.

f) The Second 30-day Period: Conducting and Completing the Investigation
    a. The CFR's review is to be completed within 30 working days following receipt of all information including the autopsy reported if one is performed.
    b. The Child Fatality Review Committee's investigation must address:
        i. The circumstances leading up to and case of death;
        ii. Details of previous agency involvement including dates and reasons for service;
        iii. Agency service prior to circumstances leading to death;
        iv. Whether intervention had been sought;
        v. Conclusion of whether services prior to death were adequate;
        vi. Whether death could have been prevented; and,
        vii. Recommendations for prevention of future similar deaths.

g) The Third 15-day Period: Transmitting the Report
    a. Following the completion of its investigation, the Child Fatality Review Committee will, within 15 days, transmit its report to DHR for the State Fatality Review Panel.
    b. Under the following circumstances, a copy of the report will be sent within 15 days to the District Attorney having jurisdiction:
        i. SIDS with no autopsy;
        ii. Accidental death that could have been prevented in intervention or supervision;
        iii. Sexually transmitted disease (or other evidence of sexual abuse by genital injury or history);
        iv. Medical causes that could have been prevented through intervention by agency or by seeking medical treatment;
        v. Suicide of a child in custody known to DHR or suspicious;

vi. Suspected or confirmed abuse;
vii. Trauma to the head or body (by possible assault) and;
viii. Homicide.

c. The report will include minority opinions of disagreement.

h) Review Process
   a. Chairperson will send case names and other identifiers to appropriate committee members.
   b. Agencies will collect their own records, if any; and share significant case information with committee or case manager as soon as possible.
   c. Committee will meet to review collective findings.
   d. Formal case presentations may be made by representatives of different disciplines using a format consistent with their own professional training and experience.
   e. Committee will discuss each question required by law.
   f. Team will arrive at an agreement and, when necessary, provide space for minority opinion.
   g. Panel report will be submitted.
   h. If additional investigation is requested by the group, then a report will be written and sent to appropriate parties.

i) Disagreements
   a. Disagreements about membership or reports should be resolved by the committee.
   b. Disputes may be referred to the Judge having the jurisdiction for the Committee or to the State Agencies receiving reports 'or the State Team.

j) Local Report Forms
   a. The form shall include space for all of the questions noted above.
   b. The DFCS child death form shall be added, when available to the case file of the Committee.
   c. Records for the committee shall be stored in such a way to maintain the integrity of the case file.
   d. Larger counties may need to computerize their record systems.

k) Relationship to State
   a. The Chair of the committee shall serve as a State contact for the committee with expectations made by the Committee.
   b. Agencies shall still contact their own State counterpart Agency.
   c. The State will have responsibility to let the local Committee know about disagreements or problems with the cases reported.

l) Children Expressing Suicidal Thoughts and Acts
   a. When any agency receives a report that a child 17 year of age or younger has expressed suicidal thoughts or threats, then that agency should sent a copy of the report to the School District to the attention of a School Social Worker.

2) Georgia Child Fatality Review Committee; Statute

The unexpected death of a child creates a crisis for the family, friends, and community. To reduce such tragedies, the Georgia Legislature mandated that each county establish a Child Fatality Review committee to review any sudden or unexplained death of a child under the age of 18. The Protocol committee will cooperate and work with the Review committee in investigations of all reviewable deaths.

O.C.G.A. § 19-15-3. County multiagency child fatality review committee; chairperson; eligible deaths for review; notification to coroner; reporting to chairperson; committee review

(a)(1) Each county shall establish a local review committee as provided in this Code section.
The review committee shall be charged with reviewing all deaths as set forth in subsection (e) of this Code section to determine manner and cause of death and if the death was preventable. The chief superior court judge of the circuit in which the county is located shall establish a review committee composed of, but not limited to, the following members:

(A) The county medical examiner or coroner;
(B) The district attorney or his or her designee;
(C) A county department of family and children services representative;
(D) A local law enforcement representative;
(E) The sheriff or county police chief or his or her designee;
(F) A juvenile court representative;
(G) A county public health department representative; and

(H) A county mental health representative.

The district attorney or his or her designee shall serve as the chairperson to preside over all meetings.

(a) Review committee members shall recommend whether to establish a review committee for that county alone or establish a review committee with and for the counties within that judicial circuit.

(b) The chief superior court judge shall appoint persons to fill any vacancies on the review committee should the membership fail to do so.

(c) If any designated agency fails to carry out its duties relating to participation on the review committee, the chief superior court judge of the circuit or any superior court judge who is a member of the Panel shall issue an order requiring the participation of such agency. Failure to comply with such order shall be cause for punishment as for contempt of court.

(d) Deaths eligible for review by review committees are all deaths of children ages birth through 17 as a result of:

(1) Sudden Infant Death Syndrome;

(2) Any unexpected or unexplained conditions;

(3) Unintentional injuries;

(4) Intentional injuries;

(5) Sudden death when the child is in apparent good health;

(6) Any manner that is suspicious or unusual;

(e) Medical conditions when unattended by a physician. For the purpose of this paragraph, no person shall be deemed to have died unattended when the death occurred while the person was a patient of a hospice licensed under Article 9 of Chapter 7 of Title 31;

(f) Serving as an inmate of a state hospital or a state, county, or city penal institution; or

(g) Child abuse.

(h) It shall be the duty of any law enforcement officer, medical personnel, or other person having knowledge of the death of a child to immediately notify the coroner or medical examiner of the county wherein the body is found or death occurs.

(i) If the death of a child occurs outside the child's county of residence, it shall be the duty of the medical examiner or coroner in the county where the child died to notify the medical examiner or coroner in the county of the child's residence. It shall be the duty of such medical examiner or coroner to provide the protocol committee of the county of such child's residence with copies of all information and reports required by subsections (i) and (j) of this Code section.

(k) When a county medical examiner or coroner receives a report regarding the death of any child he or she shall within 48 hours of the death notify the chairperson of the review committee for the county or circuit in which such child resided at the time of death.

(i) The coroner or county medical examiner shall review the findings regarding the cause and manner of death for each child death report received and respond as follows:

(1) If the death does not meet the criteria for review pursuant to subsection (e) of this Code section, the coroner or county medical examiner shall sign the form designated by the panel stating that the death does not meet the criteria for review. He or she shall forward the form and findings, within seven days of the child's death, to the chairperson of the review committee for the county or circuit of the child's residence; or

(2) If the death meets the criteria for review pursuant to subsection (e) of this Code section, the coroner or county medical examiner shall complete and sign the form designated by the panel stating the death meets the criteria for review. He or she shall forward the form and findings, within seven days of the child's death, to the chairperson of the review committee for the county or circuit of the child's residence.

(j) When the chairperson of a review committee receives a report from the coroner or medical examiner regarding the death of a child, such chairperson shall review the report and findings regarding the cause and manner of the child's death and respond as follows:

(1) If the report indicates the child's death does not meet the criteria for review and the chairperson agrees with this decision, the chairperson shall sign the form designated by the panel stating that the death does not meet the criteria for review. He or she shall forward the form and findings to the panel within seven days of receipt;

(2) If the report indicates the child's death does not meet the criteria for review and the chairperson disagrees with this decision, the chairperson shall follow the procedures for deaths to be reviewed pursuant to subsection (k) of this Code section;

(3) If the report indicates the child's death meets the criteria for review and the chairperson disagrees with this decision, the chairperson shall sign the form designated by the panel stating that the death does not meet the criteria for review. The chairperson shall also attach an explanation for this decision; or

(4) If the report indicates the child's death meets the criteria for review and the chairperson agrees with this decision, the chairperson shall follow the procedures for deaths to be reviewed pursuant to subsection (k) of this Code section.

(k) When a child's death meets the criteria for review, the chairperson shall convene the review committee within 30 days after receipt of the report for a meeting to review and investigate the cause and circumstances of the death. Review committee members shall provide information as specified in this subsection, except where otherwise protected by law:

(1) The providers of medical care and the medical examiner or coroner shall provide pertinent health and medical information regarding a child whose death is being reviewed by the review committee;

(2) State, county, or local government agencies shall provide all of the following data on forms designated by the panel for reporting child fatalities:

(A) Birth information for children who died at less than one year of age including confidential information collected for medical and health use;

(B) Death information for children who have not reached their eighteenth birthday;

(C) Law enforcement investigative data, medical examiner or coroner investigative data, and parole and probation information and records;

(D) Medical care, including dental, mental, and prenatal health care; and

(E) Pertinent information from any social services agency that provided services to the child or family; and

(3) The review committee may obtain from any superior court judge of the county or circuit for which the review committee was created a subpoena to compel the production of documents or attendance of witnesses when that judge has made a finding that such documents or witnesses are necessary for the review committee's review. Service of, objection to, and enforcement of subpoenas authorized by this Code section shall be governed by the procedures set forth in Chapter 13 of Title 24. However, this Code section shall not modify or impair the privileged communications as provided by law except as otherwise provided in Code Section 19-7-5.

(4) Disclosure of protected health information pursuant to this subsection shall be considered to be for a law enforcement purpose, and the review committee shall be considered to be a law enforcement official within the meaning of the rules and regulations adopted pursuant to the federal Health Insurance Portability and Accountability Act of 1996. Disclosure of confidential or privileged matter to the review committee pursuant to this Code section shall not serve to destroy or in any way abridge the confidential or privileged character thereof, except for the purpose for which such disclosure is made.

(l) The review committee shall complete its review and prepare a report of the child's death within 20 days, weekends and holidays excluded, following the first meeting held after receipt of the county medical examiner or coroner's report. The review committee's report shall:

(1) State the circumstances leading up to death and cause of death;

(2) Detail any agency involvement prior to death, including the beginning and ending dates and kinds of services delivered, the reasons for initial agency activity, and the reasons for any termination of agency activities;(3) State whether any agency services had been delivered to the family or child prior to the circumstances leading to the child's death;

(4) State whether court intervention had ever been sought;

(5) State whether there have been any acts or reports of violence between past or present spouses, persons who are parents of the same child, parents and children, stepparents and stepchildren, foster parents and foster children, or other persons living or formerly living in the same household;

(6) Conclude whether services or agency activities delivered prior to death were appropriate and whether the child's death could have been prevented;

(7) Make recommendations for possible prevention of future deaths of similar incidents for children who are at risk for such deaths; and

(8) Include other findings as requested by the Panel.

(m) The review committee shall transmit a copy of its report within 15 days of completion to the panel.

(n) The review committee shall transmit a copy of its report within 15 days following its completion to the district attorney of the county or circuit for which the review committee was created if the report concluded that the child named therein died as a result of:

(1) Sudden Infant Death Syndrome when no autopsy was performed to confirm the diagnosis;

(2) Accidental death when it appears that the death could have been prevented through intervention or supervision;

(3) Any sexually transmitted disease;

(4) Medical causes which could have been prevented through intervention by an agency or by seeking medical treatment;

(5) Suicide of a child in custody or known to the Department of Human Services or when the finding of suicide is suspicious;

(6) Suspected or confirmed child abuse;

(7) Trauma to the head or body; or

(8) Homicide.

(o) Each review committee shall issue an annual report no later than the first day of July each year. The report shall:

(1) Specify the numbers of reports received by such review committee from a county medical examiner or coroner pursuant to subsection (h) of this Code section for the preceding calendar year;

(2) Specify the number of reports of child fatality reviews prepared by the review committee during such period;

(3) Be published at least once annually in the legal organ of the county or counties for which the review committee was established with the expense of such publication paid each by such county; and

(4) Be transmitted, no later than the fifteenth day of July each year to the Panel.

3) Child Death and Near-Death Contact List for Law Enforcement, DFCS, and District Attorney

In situations involving a child fatality or near-death incident, law enforcement should contact both DFCS and the Office of the District Attorney by using the numbers below:

DFCS:

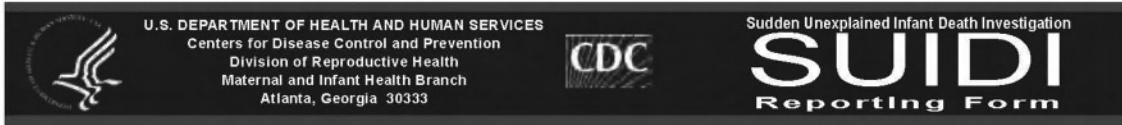
Brooke Ford - Director - 404 576 5107
Taylor Smithey - Program Director - 706 671 0464
Hailey Gagner - CPS Administrator - 470 859 7746

**If unable to reach, call intake and select the option for first responder/law enforcement to speak to on-call supervisor.

Office of the District Attorney:

Susan Treadaway, District Attorney- 470-281-7626
Katie Gropper, Chief Assistant District Attorney- 770-547-8462
Brandon Owens, Senior Investigator- 678-687-4025
Rachel Hines, Deputy Chief Assistant District Attorney and Fatality Chair- 470-302-6241

K. SUDDEN UNEXPLAINED INFANT DEATH INVESTIGATION (SUIDI) FORM


U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
Division of Reproductive Health
Maternal and Infant Health Branch
Atlanta, Georgia 30333

CDC

Sudden Unexplained Infant Death Investigation
SUIDI
Reporting Form

INVESTIGATION DATA

Infant's Last Name	Infant's First Name	Middle Name	Case Number

Sex: ☐ Male ☐ Female Date of Birth: ______ Age: ______ SS#: ______

Race: ☐ White ☐ Black/African Am. ☐ Asian/Pacific Isl. ☐ Am. Indian/Alaskan Native ☐ Hispanic/Latino ☐ Other ______

Infant's Primary Residence:

Address: ______ City: ______ County: ______ State: ______ Zip: ______

Incident Address: ______ City: ______ County: ______ State: ______ Zip: ______

Contact Information for Witness:

Relationship to deceased: ☐ Birth Mother ☐ Birth Father ☐ Grandmother ☐ Grandfather

☐ Adoptive or Foster Parent ☐ Physician ☐ Health Records ☐ Other Describe: ______

Last: ______ First: ______ M.: ______ SS#: ______

Address: ______ City: ______ State: ______ Zip: ______

Work Address: ______ City: ______ State: ______ Zip: ______

Home Phone: ______ Work Phone: ______ Date of Birth: ______

WITNESS INTERVIEW

1 **Are you the usual caregiver?** ☐ No ☐ Yes

2 **Tell me what happened:**

______

3 **Did you notice anything unusual or different about the infant in the last 24 hrs?**
☐ No ☐ Yes Specify: ______

4 **Did the infant experience any falls or injury within the last 72 hrs?**
☐ No ☐ Yes Specify: ______

5 **When was the infant LAST PLACED?**
Date: ______ Military Time: ______ Location (room): ______

6 **When was the infant LAST KNOWN ALIVE(LKA)?**
Date: ______ Military Time: ______ Location (room): ______

7 **When was the infant FOUND?**
Date: ______ Military Time: ______ Location (room): ______

8 **Explain how you knew the infant was still alive.**

______

9 **Where was the infant - (P)laced, (L)ast known alive, (F)ound** (write **P**, **L**, or **F** in front of appropriate response)?

☐ Bassinet	☐ Bedside co-sleeper	☐ Car seat	☐ Chair
☐ Cradle	☐ Crib	☐ Floor	☐ In a person's arms
☐ Mattress/box spring	☐ Mattress on floor	☐ Playpen	☐ Portable crib
☐ Sofa/couch	☐ Stroller/carriage	☐ Swing	☐ Waterbed
☐ Other - describe: ______			

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WITNESS INTERVIEW (cont.)

10 In what position was the infant LAST PLACED? ☐ Sitting ☐ On back ☐ On side ☐ On stomach ☐ Unknown
Was this the infant's usual position? ☐ Yes ☐ No What was the usual position? ______

11 In what position was the infant LKA? ☐ Sitting ☐ On back ☐ On side ☐ On stomach ☐ Unknown
Was this the infant's usual position? ☐ Yes ☐ No What was the usual position? ______

12 In what position was the infant FOUND? ☐ Sitting ☐ On back ☐ On side ☐ On stomach ☐ Unknown
Was this the infant's usual position? ☐ Yes ☐ No What was the usual position? ______

13 Face position when LAST PLACED? ☐ Face down on surface ☐ Face up ☐ Face right ☐ Face left

14 Neck position when LAST PLACED? ☐ Hyperextended (head back) ☐ Flexed (chin to chest) ☐ Neutral ☐ Turned

15 Face position when LKA? ☐ Face down on surface ☐ Face up ☐ Face right ☐ Face left

16 Neck position when LKA? ☐ Hyperextended (head back) ☐ Flexed (chin to chest) ☐ Neutral ☐ Turned

17 Face position when FOUND? ☐ Face down on surface ☐ Face up ☐ Face right ☐ Face left

18 Neck position when FOUND? ☐ Hyperextended (head back) ☐ Flexed (chin to chest) ☐ Neutral ☐ Turned

19 What was the infant wearing? *(ex. t-shirt, disposable diaper)* ______

20 Was the infant tightly wrapped or swaddled? ☐ No ☐ Yes - describe: ______

21 Please indicate the types and numbers of layers of bedding both over and under infant (not including wrapping blanket):

Bedding UNDER Infant	None	Number	Bedding OVER Infant	None	Number
Receiving blankets			Receiving blankets		
Infant/child blankets			Infant/child blankets		
Infant/child comforters (thick)			Infant/child comforters (thick)		
Adult comforters/duvets			Adult comforters/duvets		
Adult blankets			Adult blankets		
Sheets			Sheets		
Sheepskin			Pillows		
Pillows			Other, specify:		
Rubber or plastic sheet					
Other, specify:					

22 Which of the following devices were operating in the infant's room?
☐ None ☐ Apnea monitor ☐ Humidifier ☐ Vaporizer ☐ Air purifier ☐ Other - ______

23 What was the temperature in the infant's room? ☐ Hot ☐ Cold ☐ Normal ☐ Other - ______

24 Which of the following items were near the infant's face, nose, or mouth?
☐ Bumper pads ☐ Infant pillows ☐ Positional supports ☐ Stuffed animals ☐ Toys ☐ Other - ______

25 Which of the following items were within the infant's reach?
☐ Blankets ☐ Toys ☐ Pillows ☐ Pacifier ☐ Nothing ☐ Other - ______

26 Was anyone sleeping with the infant? ☐ No ☐ Yes

Name of individual sleeping with infant	Age	Height	Weight	Location in relation to infant	Impairment (intoxication, tired)

27 Was there evidence of wedging? ☐ No ☐ Yes - Describe: ______

28 When the infant was found, was s/he: ☐ Breathing ☐ Not Breathing
If not breathing, did you witness the infant stop breathing? ☐ No ☐ Yes

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WITNESS INTERVIEW (cont.)

29 **What had led you to check on the infant?**

30 **Describe the infant's appearance when found.**

Appearance	Unknown	No	Yes	Describe and specify location
a) Discoloration around face/nose/mouth				
b) Secretions (foam, froth)				
c) Skin discoloration (livor mortis)				
d) Pressure marks (pale areas, blanching)				
e) Rash or petechiae (small, red blood spots on skin, membranes, or eyes)				
f) Marks on body (scratches or bruises)				
g) Other				

31 **What did the infant feel like when found?** *(Check all that apply.)*

☐ Sweaty ☐ Warm to touch ☐ Cool to touch ☐ Limp, flexible ☐ Rigid, stiff ☐ Unknown

☐ Other - specify:

32 **Did anyone else other than EMS try to resuscitate the infant?** ☐ No ☐ Yes

Who? Date: Military time: :

33 **Please describe what was done as part of resuscitation:**

34 **Has the parent/caregiver ever had a child die suddenly and unexpectedly?** ☐ No ☐ Yes

Explain:

INFANT MEDICAL HISTORY

1 **Source of medical information:** ☐ Doctor ☐ Other healthcare provider ☐ Medical record ☐ Family

☐ Mother/primary caregiver ☐ Other:

2 **In the 72 hours prior to death, did the infant have:**

Condition	Unknown	No	Yes	Condition	Unknown	No	Yes
a) Fever				h) Apnea (stopped breathing)			
b) Diarrhea				i) Decrease in appetite			
c) Excessive sweating				j) Cyanosis (turned blue/gray)			
d) Stool changes				k) Vomiting			
e) Lethargy or sleeping more than usual				l) Seizures or convulsions			
f) Difficulty breathing				m) Choking			
g) Fussiness or excessive crying				n) Other, specify:			

3 **In the 72 hours prior to death, was the infant injured or did s/he have any other condition(s) not mentioned?**

☐ No ☐ Yes - describe:

4 **In the 72 hours prior to the infants death, was the infant given any vaccinations or medications?** ☐ No ☐ Yes

(Please include any home remedies, herbal medications, prescription medicines, over-the-counter medications.)

Name of vaccination or medication	Dose last given	Date given Month	Day	Year	Approx. time (Military Time)	Reasons given/comments:
1.						
2.						
3.						
4.						

INFANT MEDICAL HISTORY (cont.)

5 At any time in the infant's life, did s/he have a history of?

Medical history	Unknown	No	Yes	Describe
a) Allergies *(food, medication, or other)*	☐	☐	☐	
b) Abnormal growth or weight gain/loss	☐	☐	☐	
c) Apnea *(stopped breathing)*	☐	☐	☐	
d) Cyanosis *(turned blue/gray)*	☐	☐	☐	
e) Seizures or convulsions	☐	☐	☐	
f) Cardiac (*heart*) abnormalities	☐	☐	☐	

6 Did the infant have any birth defects(s)? ☐ No ☐ Yes

Describe:

7 Describe the two most recent times that the infant was seen by a physician or healthcare provider:
(Include emergency department visits, clinic visits, hospital admissions, observational stays, and telephone calls)

	First most recent visit	Second most recent visit
a) Date		
b) Reason for visit		
c) Action taken		
d) Physician's name		
e) Hospital/clinic		
f) Address		
g) City		
h) State, ZIP		
i) Phone number		

8 Birth hospital name: ______ Discharge date: ______

Street address: ______

City: ______ State: ______ Zip: ______

9 What was the infant's length at birth? ______ inches or ______ centimeters

10 What was the infant's weight at birth? ______ pounds ______ ounces or ______ grams

11 Compared to the delivery date, was the infant born on time, early, or late?

☐ On time ☐ Early - how many weeks? ______ ☐ Late - how many weeks? ______

12 Was the infant a singleton, twin, triplet, or higher gestation?

☐ Singleton ☐ Twin ☐ Triplet ☐ Quadrupelet or higher gestation

13 Were there any complications during delivery or at birth? *(emergency c-section, child needed oxygen)* ☐ Yes ☐ No

Describe:

14 Are there any alerts to the pathologist? *(previous infant deaths in family, newborn screen results)* ☐ Yes ☐ No

Specify:

INFANT DIETARY HISTORY

1 **On what day and at what approximate time was the infant last fed?**

Date: ______ Military Time: ___ : ___

2 **What is the name of the person who last fed the infant?** ______

3 **What is his/her relationship to the infant?** ______

4 **What foods and liquids was the infant fed in the <u>last 24 hours</u>** (include last fed)**?**

Food	Unknown	No	Yes	Quantity (ounces)	Specify: (type and brand)
a) Breastmilk (one/both sides, length of time)					
b) Formula (brand, water source - ex. Similac, tap water)					
c) Cow's milk					
d) Water (brand, bottled, tap, well)					
e) Other liquids (teas, juices)					
f) Solids					
g) Other					

5 **Was a new food introduced in the 24 hours prior to his/her death?** ☐ No ☐ Yes

If yes, describe *(ex. content, amount, change in formula, introduction of solids)*

______

6 **Was the infant last placed to sleep with a bottle?** ☐ Yes ☐ No - if no, skip to question **9** below

7 **Was the bottle propped?** (i.e., object used to hold bottle while infant feeds) ☐ No ☐ Yes

If yes, what object was used to prop the bottle? ______

8 **What was the quantity of liquid (in ounces) in the bottle?** ______

9 **Did the death occur during?** ☐ Breastfeeding ☐ Bottle-feeding ☐ Eating solid foods ☐ Not during feeding

10 **Are there any factors, circumstances, or environmental concerns that may have impacted the infant that have not yet been identified?** *(ex. exposed to cigarette smoke or fumes at someone else's home, infant unusually heavy, placed with positional supports or wedges)*

☐ No ☐ Yes

If yes, - describe: ______

PREGNANCY HISTORY

1 **Information about the infant's birth mother:**

First name: ______ Last name: ______

Middle name: ______ Maiden name: ______

Birth date: ______ SS#: ______

Street address: ______ City: ______ State: ______ Zip: ______

How long has the birth mother been at this address? Years: ______ Months: ______

Previous Address: ______

2 **At how many weeks or months did the birth mother begin prenatal care?** ☐ No prenatal care ☐ Unknown

Weeks: ______ Months: ______

3 **Where did the birth mother receive prenatal care?** *(Please specify physician or other healthcare provider name and addresses.)*

Physician/ Provider: ______ Hospital/clinic: ______ Phone: ______

Street address: ______ City: ______ State: ______ Zip: ______

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PREGNANCY HISTORY (cont.)

4 During her pregnancy with the infant, did the mother have any complications? ☐ No ☐ Yes
(ex. high blood pressure, bleeding, gestational diabetes)

Specify: ____

5 Was the birth mother injured during her pregnancy with the infant? *(ex. auto accident, falls)* ☐ No ☐ Yes

Specify: ____

6 During her pregnancy, did she use any of the following?

	Unknown	No	Yes	Daily		Unknown	No	Yes	Daily
a) Over the counter medications					d) Cigarettes				
b) Prescription medications					e) Alcohol				
c) Herbal remedies					f) Other				

7 Currently, does any caregiver use any of the following?

	Unknown	No	Yes	Daily		Unknown	No	Yes	Daily
a) Over the counter medications					d) Cigarettes				
b) Prescription medications					e) Alcohol				
c) Herbal remedies					f) Other				

INCIDENT SCENE INVESTIGATION

1 Where did the incident or death occur? ____

2 Was this the primary residence? ☐ No ☐ Yes

3 Is the site of the incident or death scene a daycare or other childcare setting? ☐ Yes ☐ No - If no, skip to question **8**

4 How many children (under age 18) were under the care of the provider at the time of the incident or death? ____

5 How many adults (age 18 and over) were supervising the child(ren)? ____

6 What is the license number and licensing agency for the daycare?

License number: ____ Agency: ____

7 How long has the daycare been open for business? ____

8 How many people live at the site of the incident or death scene?

Number of adults (18 years or older): ____ Number of children (under 18 years old): ____

9 Which of the following heating or cooling sources were being used? *(Check all that apply)*

☐ Central air ☐ Gas furnace or boiler ☐ Wood burning fireplace ☐ Open window(s)
☐ A/C window unit ☐ Electric furnace or boiler ☐ Coal burning furnace ☐ Wood burning stove
☐ Ceiling fan ☐ Electric space heater ☐ Kerosene space heater ☐ Floor/table fan
☐ Electric baseboard heat ☐ Electric (radiant) ceiling heat ☐ Window fan ☐ Unknown
☐ Other - specify: ____

10 Indicate the temperature of the room where the infant was found unresponsive:

☐ Thermostat setting ☐ Thermostat reading ☐ Actual room temp. ☐ Outside temp.

11 What was the source of drinking water at the site of the incident or death scene? *(Check all that apply.)*

☐ Public/municipal water ☐ Bottled water ☐ Well ☐ Unknown ☐ Other - Specify: ____

12 The site of the incident or death scene has: *(check all that apply)*

☐ Insects ☐ Mold growth ☐ Smoky smell *(like cigarettes)*
☐ Pets ☐ Dampness ☐ Presence of alcohol containers
☐ Peeling paint ☐ Visible standing water ☐ Presence of drug paraphenalia
☐ Rodents or vermin ☐ Odors or fumes - Describe: ____
☐ Other - specify: ____

13 Describe the general appearance of incident scene: *(ex. cleanliness, hazards, overcrowding, etc.)*

Specify: ____

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INVESTIGATION SUMMARY

1 **Are there any factors, circumstances, or environmental concerns about the incident scene investigation that may have impacted the infant that have not yet been identified?**

2 **Arrival times**

	Military time
Law enforcement at scene:	:
DSI at scene:	:
Infant at hospital:	:

Investigator's Notes

1 **Indicate the task(s) performed**

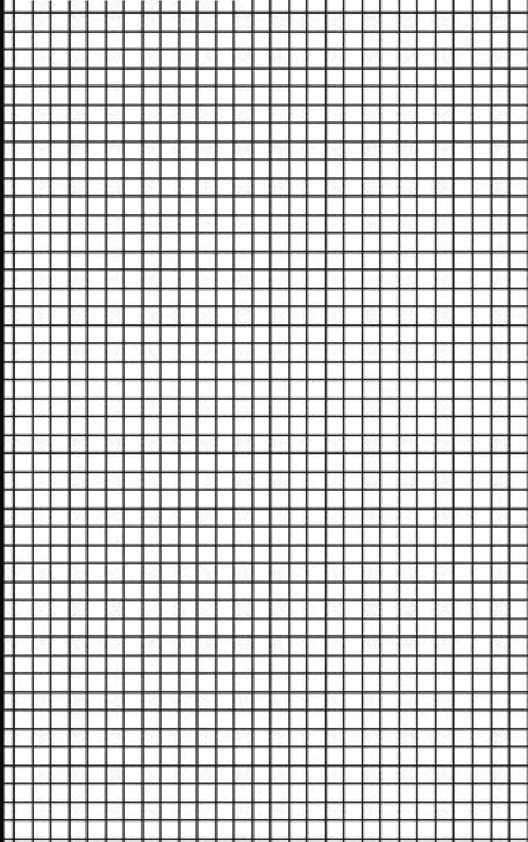
- [ ] Additional scene(s)? (forms attached)
- [ ] Materials collected/evidence logged
- [ ] Notify next of kin or verify notification
- [ ] Doll reenactment/scene re-creation
- [ ] Referral for counseling
- [ ] 911 tape
- [ ] Photos or video taken and noted
- [ ] EMS run sheet/report

2 **If more than one person was interviewed, does the information differ?** [ ] No [ ] Yes

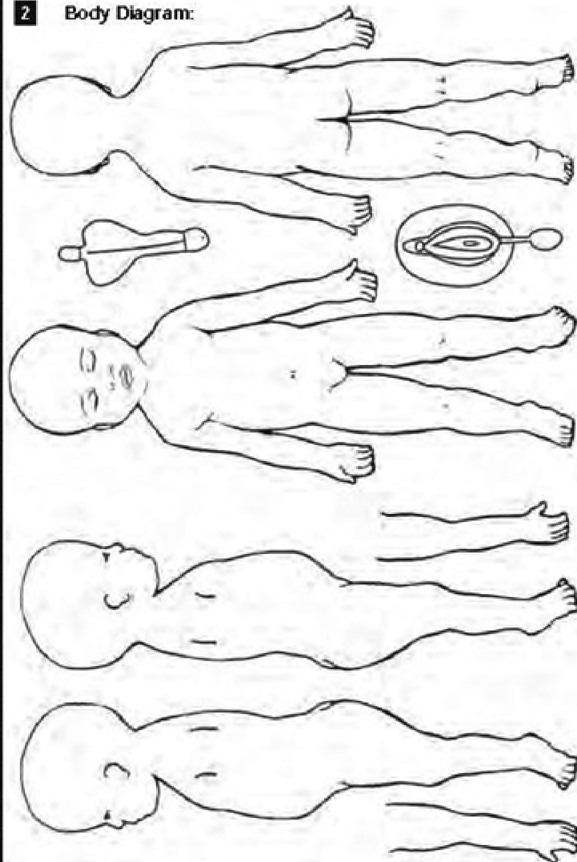
If yes, detail any differences, inconsistencies of relevant information: *(ex. placed on sofa, last known alive on chair.)*

INVESTIGATION DIAGRAMS

1 **Scene Diagram:**



2 **Body Diagram:**



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SUMMARY FOR PATHOLOGIST

Case Information

1 Investigator information Name: ____ Agency: ____ Phone: ____

	Date	Military time
Investigated:		:
Pronounced dead:		:

2 Infant's information: Last: ____ First: ____ M: ____ Case #: ____

Sex: ☐ Male ☐ Female Date of Birth: ____ Age: ____

Race: ☐ White ☐ Black/African Am. ☐ Asian/Pacific Islander ☐ Am. Indian/Alaskan Native ☐ Hispanic/Latino ☐ Other: ____

Sleeping Environment

1 Indicate whether preliminary investigation suggests any of the following:

Yes	No	
☐	☐	Asphyxia *(ex. overlying, wedging, choking, nose/mouth obstruction, re-breathing, neck compression, immersion in water)*
☐	☐	Sharing of sleep surface with adults, children, or pets
☐	☐	Change in sleep condition *(ex. unaccustomed stomach sleep position, location, or sleep surface)*
☐	☐	Hyperthermia/Hypothermia *(ex. excessive wrapping, blankets, clothing, or hot or cold environments)*
☐	☐	Environmental hazards *(ex. carbon monoxide, noxious gases, chemicals, drugs, devices)*
☐	☐	Unsafe sleep condition *(ex. couch/sofa, waterbed, stuffed toys, pillows, soft bedding)*

Infant History

Yes	No	
☐	☐	Diet *(e.g., solids introduced, etc.)*
☐	☐	Recent hospitalization
☐	☐	Previous medical diagnosis
☐	☐	History of acute life-threatening events *(ex. apnea, seizures, difficulty breathing)*
☐	☐	History of medical care without diagnosis
☐	☐	Recent fall or other injury
☐	☐	History of religious, cultural, or ethnic remedies
☐	☐	Cause of death due to natural causes other than SIDS *(ex. birth defects, complications of preterm birth)*

Family Info

Yes	No	
☐	☐	Prior sibling deaths
☐	☐	Previous encounters with police or social service agencies
☐	☐	Request for tissue or organ donation
☐	☐	Objection to autopsy

Exam

Yes	No	
☐	☐	Pre-terminal resuscitative treatment
☐	☐	Death due to trauma (injury), poisoning, or intoxication

Investigator Insight

Yes	No	
☐	☐	Suspicious circumstances
☐	☐	Other alerts for pathologist's attention

Any "Yes" answers above should be explained in detail (description of circumstances):

____

Pathologist

2 Pathologist information Name: ____

Agency: ____ Phone: ____ Fax: ____

L. SAMPLE PROTOCOL COMMITTEE ANNUAL REPORT

<u>Protocol Committee - Annual Report</u>

County: Judicial Circuit:

Date of Submission:

Pursuant OCGA § 19-15-2(i) the protocol committee shall issue an annual report no later than the first day of July.

The report shall include the following:

1. Evaluate the extent to which the child abuse investigations during the 12 months prior to the report have complied with the child abuse protocol
2. Recommend measure to improve compliance
3. Describe which measures taken within the county to prevent child abuse have been successful

Activities/Concerns

____
Chair - Printed Name and Title
Address
Phone
Email

The report shall be submitted to the:

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

M. DFCS MANDATED REPORTER FORM

BRIAN P. KEMP
GOVERNOR

TOM C. RAWLINGS
DIVISION DIRECTOR

Georgia Child Protective Services Mandated Reporter Form

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

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

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

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

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

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

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

SAFE CHILDREN. STRENGTHENED FAMILIES. STRONGER GEORGIA.
2 PEACHTREE STREET NW, SUITE 19-490 | ATLANTA, GA 30303
September 2020

DATE: Click here to enter text.

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

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

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

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

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

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

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

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

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

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

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

CHILDREN

Child's Name	Victim	Sex	Race	DOB	SSN	Grade Level

OTHER HOUSEHOLD MEMBERS:

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

OTHER ADULTS OF SIGNIFICANCE NOT RESIDING IN HOME:

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

N. UNDERSTANDING AND AGREEMENT; SIGNATURES

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

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

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

By signing below, you ensure as agency head/designated representative, you will be responsible for distribution and training of this protocol to all pertinent staff.

After signing this page, please return to Rachel Hines, Office of the District Attorney, 90 North Street, Suite 390, Canton, Georgia, 30114.

____
Agency

____
Agency Head

____
Agency Representative

Signing agencies are:
District Attorney
Chief Superior Court Judge
Chief State Court Judge
Chief Magistrate Court Judge
Chief Juvenile Court Judge
Solicitor General
Sheriff
School District
Coroner
Department of Family and Children Services
Health Department
Highland Rivers Mental Health
Canton Department of Community Supervision
Cherokee Probation Services
Fire and Emergency Services
Department of Juvenile Justice
Ball Ground Police Department
Canton Police Department
Holly Springs Police Department
Woodstock Police Department
Cherokee Multi-Agency Narcotics Squad
Anna Crawford Child Advocacy Center
Court Appointed Special Advocates
Northside Hospital Cherokee
School Police Department
The Children’s Haven
LiveSafe Resources

Cherokee County Child Abuse Protocol Signatures (September 2023)

Cherokee Multi-Agency Narcotics Squad
Agency

Director Walter Jones
Agency Head

Director Walter Jones
Agency Representative

Magistrate Court
Agency

Judge James Drane
Agency Head

Sophie Fayler
Agency Representative

Office of the Cherokee County Solicitor-General
Agency

Todd Hayes, Solicitor-General
Agency Head

Todd Hayes, Solicitor-General
Agency Representative

Highland Rivers Community Service Board
Agency

Agency Head

Agency Representative

LiveSafe Resources
Agency

Lisa M Mello
Agency Head

M. Ryan Crosby, BSN, RN, SANE-A
Agency Representative

State Court

Agency

Chief Judge, State Court

Agency Head

[signature]

Agency Representative

Cherokee County School District

Agency

Dr. Debora Murdock

Agency Head

Debora Murdock

Agency Representative

Cherokee County School District Police Department

Agency

Buster Cushing [signature]

Agency Head

Chris Taylor [signature]

Agency Representative

CASA of Cherokee County

Agency

Julie Carter

Agency Head

Julie Carter

Agency Representative

Cherokee County Coroner Office

Agency

Sally Sims MSN ABMDI Coroner

Agency Head

Agency Representative

Superior Court Judge
Agency
Chief Judge Ellen McElyea
Agency Head
Shannon Wallace
Agency Representative

Woodstock Police Department
Agency

Agency Head

Agency Representative

Ball Ground Police Department
Agency
Robert B. Reeves Chief of Police
Agency Head
Robert B. Reeves
Agency Representative

Cherokee County Dept. of Family & Children Svcs.
Agency

Agency Head
Brooke Ford, Director
Agency Representative

Cherokee Child Advocacy Council, Inc.
anna crawford Children's Center
Agency
Amy J. Economopoulos
Executive Director
Agency Head

Agency Representative

Cherokee Probation Services

Agency

Agency Head

Agency Representative

JUVENILE COURT

Agency

Agency Head

JENNIFER DAVIS

Agency Representative PRESIDING JUVENILE COURT JUDGE

CHEROKEE COUNTY SHERIFF'S OFFICE

Agency

, FRANK REYNOLDS

Agency Head

CAPT / CAPT LEE HANDY

Agency Representative

Holly Springs Police Dept.

Agency

Agency Head

Agency Representative

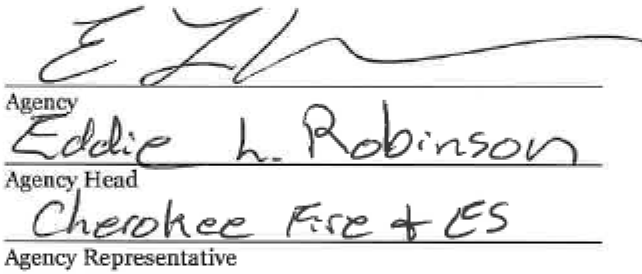
District Attorney

Agency

Susan K. Treadaway

Agency Head

Agency Representative



Cherokee County Health Department

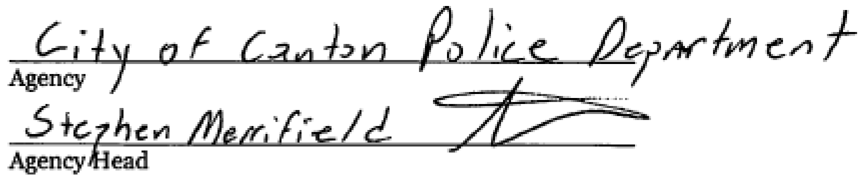
Agency

Marie Smith, RN
District Nursing Director, North Georgia Health District 1-2

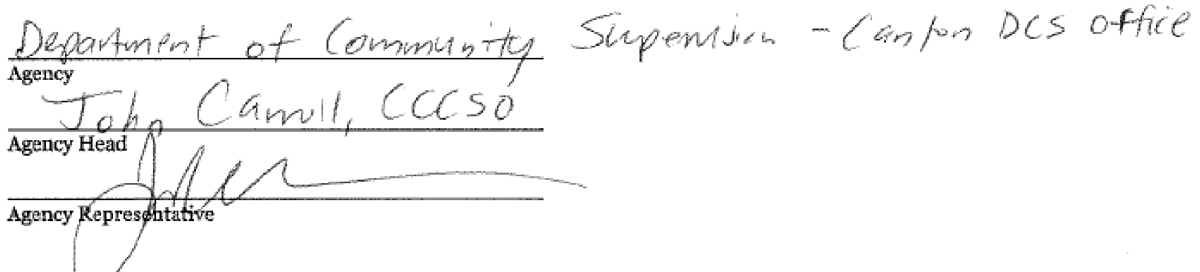
Agency Head

Karen Mathis, RN

Agency Representative



Agency Representative



Department of Juvenile Justice

Agency

Agency Head

Rusty Rodgers

Agency Representative