

“Children are the world’s most valuable resource and its best hope for the future.”

~ John Fitzgerald Kennedy



Child Abuse & Neglect

A Reporting Guide for Health Professionals

TEAM for West Virginia Children
www.teamwv.org • www.preventchildabusewv.org



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TO REPORT CHILD ABUSE OR NEGLECT, CALL YOUR LOCAL CHILD PROTECTIVE SERVICES DURING BUSINESS HOURS or the W.Va. Child Abuse and Neglect Hotline (24 hours a day): 1-800-352-6513 - Voice/TDD Accessible

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Childhood is the most beautiful
of all life's seasons.

~Author Unknown

Introduction

Ensuring Children's Rights

While everyone should be concerned about child abuse and neglect, certain groups of people are more likely to have the opportunity to recognize and report abuse and neglect. Some of those people are required by law to do so. As a health professional, you are one of those people.

This booklet is designed to assist you in that role. By taking the time to read through this material, you can become more discerning in your observations and have a better understanding of the child abuse and neglect reporting process.

This booklet contains information on:

- West Virginia law addressing child abuse and neglect
- Medical and behavioral indicators of possible abuse or neglect
- Issues and concerns about reporting
- Procedures for making a report
- A brief explanation of what happens when a report is made

Your expertise
and collaboration
are essential to
ensuring the health
and safety of
West Virginia's
children.

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“Children will not remember you for the material things you provided but for the feeling that you cherished them.”

~Richard L. Evans



1. Recognizing Child Abuse and Neglect

Reasons for Abuse/Neglect

Child abuse and neglect occur in all cultural, ethnic, occupational, and socioeconomic groups. There are certain known factors that increase the likelihood of abuse or neglect in families. They include:

- Parental predisposition towards maltreatment (perhaps as a result of being abused or neglected as a child).
- Stress within the home, such as marital, employment, or financial problems.
- Parental substance abuse.
- Lack of parenting knowledge or skills.
- Poor impulse control and low level of frustration tolerance.
- Isolation from the support of family and friends.

Legal Definitions

According to West Virginia law [WV Code 49-1-3], an abused or neglected child is any child whose parent, guardian, or custodian (regardless of age) harms or threatens the child's health or welfare by:

- Knowingly or intentionally inflicting, attempting to inflict or knowingly allowing another person to inflict physical injury or mental or emotional injury.
- Sexual abuse or sexual exploitation.
- The sale or attempted sale of the child.
- Refusal, failure, or inability to supply the child with necessary food, clothing, shelter, supervision, medical care or education.
- Excessive corporal punishment.
- Domestic or family violence causing substantial emotional injury which harms or threatens the child's health or welfare.
- Negligent treatment or maltreatment.
- Abandonment, defined as a child without necessary food, clothing, shelter, medical care, education or supervision because of the disappearance or absence of the child's parent or custodian.

Operational Definitions

Physical Abuse

Physical abuse is defined as any act which, regardless of intent, results in non-accidental physical injury. Inflicted physical injury most often represents severe corporal punishment. Physical abuse can range from minor bruises and lacerations to severe neurologic trauma and death.

Physical Neglect

Physical neglect is defined as the failure to provide for a child's physical survival needs to the extent that there is harm or risk of harm to the child's health and safety. Physical neglect is often chronic in nature and includes inadequate nutrition, clothing, shelter, hygiene, supervision, and medical or dental care.

Sexual Abuse

Sexual abuse is defined as acts of sexual assault and sexual exploitation of minors. Sexual abuse encompasses a broad range of behaviors and may consist of many acts over a long period of time or a single incident. Sexual abuse is generally perpetrated by someone known to the child and often does not involve violence. Victims include males and females who range in age from less than one year through adolescence. Specifically, sexual abuse includes:

- incest.
- rape.
- intercourse.
- oral-genital contact.
- fondling.
- sexual propositions or enticements.
- indecent exposure.
- child pornography.
- child prostitution.

Emotional Maltreatment

Mental/emotional maltreatment is defined as a **pattern** of acts by the caretaker that results in harm to the child's psychological or emotional health or development. The child typically demonstrates dysfunction as a result of the caretaker's behavior. Psychological assessment is recommended.

Emotional maltreatment can include patterns of:

- rejection.
- intimidation.
- ignoring.
- ridiculing.
- isolation.

Medical Indicators of Abuse/Neglect

The indicators described should be considered in light of the explanation provided, the child's or family's medical history, and the child's ability to self-inflict injury.

The health professional should routinely ask: *Is this injury consistent with the history given and the child's developmental capabilities?*

Abuse should be suspected when the explanation/history does not fit the injury.

SKIN TRAUMA

Bruises/Lacerations

Suspected Child Abuse

- symmetrical bruises.
- clustered bruises.
- bruises in different stages of healing.
- bruises on buttocks or lower back.
- facial bruises (especially on an infant).
- bruises on inner thigh or genital area.
- bruises on earlobe or behind ear.
- laceration of frenula lips or tongue.
- pharyngeal injuries, tears, or diverticulae.
- geometric bruises, scars which suggest the pattern of an instrument, such as:
 - loop marks
 - strap or belt marks
 - lash marks
 - linear marks
 - rectangular marks
- hand marks.
- grab, squeeze, or pinch marks.
- neck marks (choke or tie).
- human adult bite marks.

- subgaleal hemorrhages.
- circumferential bruises/abrasions.
- bruises at corner of the mouth.
- bald patches interspersed with normal hair growth.
- abrasions/lacerations.
- periorbital hematoma.

Differential Diagnosis

- Mongolian spots.
- bleeding disorders.
- playmate-inflicted biting. If the point-to-point distance between the center of the canines is less than 3 cm, the bite marks were inflicted by another child with primary teeth; a distance larger than 3 cm indicates the bite marks were inflicted by someone with permanent teeth, usually 8 or more years of age.
- ethnic practices, such as Cao Gio (coin rubbing) or cupping.
- phytophotodermatitis.
- allergic periorbital discoloration.
- infections such as hemophilus influenza or meningococemia.
- Henoch-Schoenlein purpura.
- impetigo.
- self-induced trauma.
- malignancies.
- collagen vascular disorders.

BURNS

Suspected Child Abuse

- cigarette burns (circular; often found on palms, face, soles, abdomen).
- rope burns.
- electrical burns.
- chemical burns.
- burns on lips or tongue.
- immersion burns – characteristically produce sharp lines of demarcation; appear on buttocks, perineum, genitalia, or extremities – “glove” or “stocking” distribution with sparing of areas of flexion.
- contact burns.
- burns in configuration of common household utensil or appliance.

Differential Diagnosis

- impetigo – bullous and regular.
- scaled skin syndrome.
- accidental burn.

INTERNAL/FACIAL INJURIES

Blows to Midline Area

Suspected Child Abuse

- chylous ascites from injured lymphatic system.
- laceration of liver or spleen.
- renal injury.
- laceration of the pancreas with subsequent pancreatitis and pseudocyst formation.
- fractured ribs.
- spinal cord injury with attendant paralysis and urinary incontinence.
- projectile vomiting and tenderness in abdomen.
- ruptures of small intestine or large bowel (acute abdomen).
- hematoma of the duodenum or jejunum (acute abdomen).
- rupture of the inferior vena cava.
- contusion or pneumohemothorax of the lung.
- fever, rigid abdomen, signs of peritonitis, low or decreased bowel sounds and rebound tenderness.
- altered mental status.

Note: Bruises may be absent from infants and small children who suffer severe internal injury such as rupture of a hollow viscus or hematoma of the liver or bowel.

SEVERE SHAKING OR BLOW TO THE HEAD

Suspected Child Abuse

- traumatic cataract.
- dislocated lens.
- retinal hemorrhage.
- periorbital ecchymosis (bruise).
- detached retina, especially bilateral detachments.
- hemorrhages in pinna (external ear) from slap.

- septal hematoma.
- subdural hematoma.
- subgaleal hematoma.
- cephalhematoma.
- subconjunctival hemorrhage.
- hemorrhage in vitreous.
- choroidal rupture.
- hyphema.
- rupture of tympanic membrane without infection.
- deviation of nasal septum.
- dislocation of the spine, bleeding in and around spinal cord.
- loosened, missing teeth.
- bruising over mastoid, Battle's Sign.
- bald patches in hair.
- fractures of extremities (see next section).

Note: Frequently the shaken infant will show no evidence of external bruising unless combined with a blow to the head.

Differential Diagnosis

Accidental fall. Helfer, Slovis, and Black studied 246 children who accidentally fell from a crib or bed: 80% suffered no injury; 18% had single lacerations or bruises; 1% had single, linear, non-depressed skull fractures with no accompanying neurological complications; 1% had fractures of other locations, most frequently the clavicle or humerus. No child had a subdural or epidural hematoma or life-threatening injury.

INJECTIONS

Suspected Child Abuse or Neglect

- overmedication.
- presence of depressant in system.
- ingestion of poison.
- multiple ingestions.
- unexplained or unexplainable chronic symptoms (Munchausen's Syndrome by Proxy).

SKELETAL INJURIES

Suspected Child Abuse

- **METAPHYSEAL FRACTURE**

Pathognomonic of abuse. Occurs by shaking; result of rapid acceleration and deceleration of bone extremity. If suspected, a repeat examination should be done within two weeks.

- **initially observed** – may appear as a subtle nick or break in the cortex or a small chip in metaphysis.
- **after first week of trauma** – area of periosteal new bone at the metaphysis or early new bone in the diaphysis.
- **several weeks/months** – external cortical thickening, metaphyseal cupping and deforming; frequently, all bones surrounding a single joint are affected, especially at knee.

- **EPIPHYSEAL SEPARATION**

May occur as a gross displacement or as a minor irregularity in the line of radiolucent cartilage between epiphyseal ossification center and shaft.

- **two weeks after injury** – revascularization reflected by subepiphyseal or metaphyseal demineralization.

- **DIAPHYSEAL FRACTURE**

Transverse and spiral/oblique. (Not pathognomonic of abuse, but must be evaluated with respect to developmental age.)

- **PERIOSTEAL REACTION OR ELEVATION**

- **7 to 10 days** – thin rim of periosteal new bone at the outer edge of hematoma or bleeding into bone.
- **several weeks** – periosteal new bone becomes thicker and shaft remodels.

- **SEPARATED PERIOSTEUM**

Produces new bone so that a calcified envelope or involucrum surrounds the denuded portion of bone.

- **RIB FRACTURES**

Occur from severe squeezing.

- **7 to 10 days** – development of callus formation.

- **SKULL TRAUMA**

Soft tissue manifestations with focal soft tissue swelling.

More extensive intracranial damage if frank skull fracture evident.

- **new fractures** may be difficult to evaluate because skull fracture fragment often will have fibrous union but not bony union.
- focal soft tissue usually an acute injury; lack of soft tissue swelling more likely to be **former trauma**.

- **FRACTURE OF THE MANDIBLE**

- **FRACTURE OF STERNUM OR SCAPULAE**

- **NON-BONY INJURY TO BRAIN**

intracerebral hemorrhage.

intraventricular hemorrhage.

subdural hemorrhage – old subdural hemorrhage may manifest radiographically as a curvilinear calcific density in the area of the subdural hematoma.

- **SPINAL SHAFT FRACTURE**

- **SPINAL TRAUMA**

- **NOTCHING OF VERTEBRAL BODY**

- **COMPRESSION OF VERTEBRAL BODY**

- **MULTIPLE INJURIES IN VARIOUS STAGES OF HEALING**

Careful dating of injuries is medically and legally important, may serve as photo-history of abusive pattern.

- **RECURRENT INJURY TO SAME SITE**

Will produce abundant subperiosteal new bone.

Differential Diagnosis

- Underlying bony tumors; e.g., focal osteogenic sarcoma genic sarcoma.
- bone cysts (unicameral cysts).

Differential Point

long bone survey.
clinical history.

- Perinatal trauma.
cephalhematoma.
subdural hematoma.
caput succedaneum.

Differential Point

perinatal history.

- Scurvy – produces massive subperiosteal hematoma in healing stage.

Differential Point

all bones show generalized osteoporosis.
cortices are thin.
trabecular architecture ill-defined.
bones have “ground glass” appearance.

- Osteogenesis imperfecta (brittle bones) can cause propensity for long bone fractures.

Differential Point

Generalized bony demineralization; however, there may not be any evidence of bony abnormality at the time of the first fracture (Patterson, CR, McAllion, SJ, Brit-Med Journal, 1989:299, 1451-4).
positive family history.
signs of fracture present in bone not involved in immediate trauma.
blue sclerae (in some patients).
deafness (in some).
fractures may be present at birth.

- Infantile cortical hyperostosis (Caffey’s disease) characterized by subperiosteal new bone formation.

Differential Point

no metaphyseal irregularities

- Hypophosphatasia

- Leukemia

Differential Point

petechiae/pallor.

- Metastatic tumors
metastatic neuroblastoma.
sequelae of osteomyelitis.
septic arthritis.
- Hemophilia (males)
Differential Point
bleeding around large joints.
bruising.
- Hemarthrosis
- Congenital syphilis
Differential Point
periosteal reaction bilateral along with decreased movement
of one or more extremities (Parrot's paralysis).

SEXUAL ABUSE

Suspected Sexual Abuse

FEMALE/VAGINAL FINDINGS

- lacerated hymen.
- thickened or scarred hymen.
- synechiae from labia to hymen.
- synechiae from hymen to vaginal wall.
- enlarged hymen diameter.
- lacerated, friable, or scarred fourchette.
- injury to the perineum.
- injected lesions.
- vaginitis.
- vulvitis.
- tears or infected lesions of the mouth or anus.
- presence of semen.
- discharge.
- vulvar hematoma.
- pregnancy.
- presence of sexually transmitted disease.
- recurrent urinary tract infections.

- laceration, bruise, or bleeding from external genitalia, vaginal or anal region.
- torn, stained, or bloody underclothes.
- pain or itching in genital area.
- dysuria.
- hematuria.
- enuresis.
- encopresis.
- genital erythema.

MALE FINDINGS

- bruised or swollen scrotum or penis.
- trauma to scrotum/testicles.
- abnormal markings on the penis.
- tears or infected lesions of the mouth or anus.
- presence of sexually transmitted disease.
- torn, stained, or bloody underclothes.
- pain or itching in genital area.
- anal findings (see below).

ANAL FINDINGS

- anal lacerations.
- ruptured anal sphincter.
- tears/fissures.
- edema.
- scarring (superficial and deep).
- hyperpigmentation.
- decreased tone.
- altered anal markings.
- tags.
- venus congestion.

CHRONIC FINDINGS/OLD INJURY

- attenuated hymen.
- decreased vascularity or neovascularity.
- decreased elasticity.
- scars.
- hymenal transectims.
- V & U shaped deformities.
- rolled/thickened hymenal margins.
- funneling.

Differential Diagnosis of Sexual Abuse

(Acute and Chronic)

- accidental injury: a “straddle injury” or “picket fence injury” (acute) involves the upper labia and clitoris; the underlying bone and object crushes tissues.
- acute pinworm infestation.
- labial adhesions.
- poor genital hygiene.
- foreign body.
- urethral prolapse.
- lichen sclerosus et Atrophicus, a chronic skin disease.
- urethral polyp.
- premature menses.
- UTI (urinary tract infection).
- inflammatory bowel disease.
- candidal infections.
- congenital hemangiomas.

NEGLECT

Suspected Child Neglect

- poor skin hygiene.
 - severe untreated diaper rash with associated secondary infection and hypo- or hyperpigmentation.
 - severe insect infestation.
 - severe bedsores.
- lack of medical attention for infections or injuries.
 - prolonged symptoms of pain, diarrhea, vomiting, or respiratory disease.
 - skin lesions.
- non-organic failure to thrive.
 - diagnosis is established through hospitalization.
 - weight gain of one ounce per day is considered significant.
- wasting of subcutaneous tissue.
- dull, “vacant” expression.
- pallor suggesting anemia.

- long-standing untreated medical problems.
 - chronically inadequate dental care.
 - failure to provide required medication and/or in-home medical care.
 - repeated broken appointments.
- chronic malnutrition.
 - significant and prolonged deficiency of elements necessary to child's health and well-being.
- flat head on infant (generally back of head from lack of position change).
- bald spots on infant (generally back of head from surface contact).
- deprivational dwarfism.
 - small stature.
 - distended abdomen.
 - below normal weight.
 - retarded skeletal maturation.
- severe cradle cap.
- bruises on forehead from head banging.

Differential Diagnosis

- contributing factors, such as poverty, inadequate parenting knowledge, lack of transportation.
- constitutional short stature.
- folk medicine practices.
- religious practices, beliefs.
- severe acute malnutrition.
 - extreme thinness.
 - near normal bone growth.
- organic failure to thrive.
- genetic causes, such as cystic fibrosis, degenerative brain disease, chromosomal abnormalities, metabolic or endocrine disease or congenital anomalies (syndromes).
 - intrauterine or postpartum infection.
 - birth trauma with subsequent brain trauma.
- IUGR (inter-uterine growth restriction).
- lead poisoning.
- previously undiagnosed deafness, blindness, mental retardation, seizure disorder, or cerebral palsy.

Behavioral Indicators of Physical Abuse

A **combination** or **pattern** of indicators should alert you to the possibility of physical abuse.

CHILD

- **Reports injury by parents or other caretaker.**
- Complains of soreness or moves uncomfortably.
- Wears clothing inappropriate to the weather to cover injury.
- Wary of adult contacts.
- Frightened of parents.
- Apprehensive when other children cry.
- Displays destructive or cruel behavior.
- Behavioral extremes: aggressiveness or withdrawal.
- Chronic runaway (adolescent).

PARENT

- Delay in seeking medical treatment.
- Uses various hospitals or physicians for no apparent reason.
- Relates an explanation that is vague, contradicts medical findings, or is inconsistent with the child's developmental abilities.
- Attempts to conceal the child's injury or protect the identity of the person responsible.
- Unrealistic expectations of the child, beyond child's age or ability.
- Uses harsh discipline inappropriate to child's age, transgression, and condition.
- History of abuse as a child.
- Substance abuse.

Behavioral Indicators of Physical Neglect

CHILD

- Chronic uncleanliness, or poor hygiene, including lice, scabies, severe or untreated diaper rash, bedsores, body odor.
- Chronic hunger, begging, stealing food.
- Unattended physical problems or medical needs.
- Given inappropriate food, drink, or medication.
- Repeatedly ingests harmful substances.
- Developmental delay.

- Clothing inappropriate to the weather; basic articles of clothing missing.
- Assumes adult responsibilities.
- States no caretaker at home.

PARENT

- Consistent failure to keep appointments.
- Failure to follow through on obtaining necessary medical or dental care.
- Evidence of apathy or hopelessness.
- Overwhelmed by poverty or an environment they can't control.
- History of neglect as a child.
- Substance abuse.

Behavioral Indicators of Sexual Abuse

CHILD

- Reports sexual abuse.
- Detailed and age-inappropriate understanding of sexual behavior.
- Highly sexualized play.
- Unusually seductive behavior with peers, adults.
- Excessive masturbation.
- Enuresis and/or Encopresis.
- Sleep disturbances, e.g., nightmares or fear of falling asleep.
- Regressive behavior.
- Sudden noticeable changes in behavior.
- Poor peer relationships.
- Poor self-esteem.
- General feelings of shame or guilt.
- Eating disorders (bulimia and anorexia).
- Excessively concerned about homosexuality (especially boys).
- Deterioration in academic performance.
- Role reversal with parent and overly concerned about young sibling.
- Sexual promiscuity.
- Runs away.
- Attempts suicide.

PARENT

- Extremely protective of child (offending spouse).
- Shows favoritism to child, e.g., gifts, money, attention, privileges (offending spouse).
- Jealous of child (non-offending spouse).
- Marital problems.
- Non-abusing spouse/caretaker is frequently absent from the home, permitting access to child by abusing caretaker/spouse.
- Sexually abused as a child.

Indicators of Emotional Maltreatment

A combination or pattern of indicators should alert you to the possibility of emotional maltreatment.

CHILD

- Developmental lags.
- Habit disorders (sucking, biting, rocking, head banging in an older child).
- Eating disorders, including obesity or anorexia.
- Nervous disorders, such as hives, rashes, facial tics, or stomachaches .
- Regressive behaviors such as “baby talk,” bedwetting in an older child, wetting or soiling by school age child.
- Behavior extremes: compliant, passive, undemanding; aggressive, demanding, rageful, destructive.
- Cruel behavior, seeming to get pleasure from hurting others and/or animals.
- Self-destructive, attempted suicide.
- Fire setting.

PARENT

- Blames or belittles child.
- Ignores or rejects.
- Withholds love.
- Treats siblings unequally.
- Seems unconcerned about child’s problems.
- Unreasonable demands or impossible expectations without regard to child’s developmental capacity.

AT-RISK CHILDREN

Certain stressors associated with the child may place him/her at increased risk of abuse or neglect. These include:

“Children are like wet cement. Whatever falls on them makes an impression.”

~Dr. Haim Ginott



- Unplanned, unwanted pregnancy.
- Premature birth.
- Birth of a child to adolescent parents.
- Colic.
- Protracted separation of the newborn from the parent during the first months of life, disrupting parent-child bonding.
- Congenital deficiencies or abnormalities.
- Chronic Illness.
- Child with disabilities or developmental delays.
- Child with behavioral or temperamental difficulties.

Fatalities

Child deaths involving suspected abuse or neglect must be reported to the WV Office of the Chief Medical Examiner (WV Code 49-6A-3), Child Protective Services and the State Police or local law enforcement. An investigation will be conducted to assess risk of harm to other children in the home.

West Virginia has established a Child Fatality Review Team (WV Code 49-5D-5) to review the deaths of all children under the age of 18 in order to identify trends, patterns, and risk factors. This multidisciplinary review team is located within the office of the state's chief medical examiner. The team reports annually to the Governor and the Legislature and makes recommendations to reduce the number of preventable child fatalities in the state.

“Children are the living messages we send to a time we will not see.”

~ John W. Whitehead



2. Questional Situations

The Fine Line Between Abuse and Discipline

In order for children to grow up and become productive members of society, subject to society's norms, values, and rules, all children need discipline.

Discipline is a learning process designed to teach appropriate behaviors.

Unlike discipline, abuse is not a learning process. It is designed to stop behavior through inflicting pain. It does not teach alternative, correct behavior. Therefore, abused children do not learn correct behavior. They learn to avoid punishment.

The intent of the reporting law is not to interfere with appropriate discipline but to respond to extreme or inappropriate parental or caretaker actions. Actions that are excessive or forceful enough to leave injuries are considered abusive.

Distinguishing Abuse from Accident

One of the most crucial indications that a child's injuries are the result of abuse is the poor fit between the history of an injury and the actual physical evidence.

When observing an injury you suspect might be the result of abuse, consider:

- **Location of the injury.** Certain locations on the body such as the knees, elbows, shins, or forehead are more likely to sustain non-abusive injury than non-protuberant areas such as the back, thighs, genital area, buttocks, back of the legs, or face.
- **Number and frequency of injuries.** The greater the number of injuries, the greater the cause for concern. Unless the child is involved in a serious accident, a number of different injuries is unlikely. Multiple injuries in different stages of healing are suspicious.
- **Size and shape of the injury.** Non-intentional injuries usually have no defined shape. Intentional injuries – especially those inflicted with a familiar object such as stick, belt, hair brush, or looped cord – bear a resemblance to the object used.

- **Description of how the injury occurred.** If an injury is non-intentional, there should be a reasonable explanation of how it happened that is consistent with the presentation of the injury. Injuries that are inconsistent with the explanation are cause for suspicion.
- **Consistency of injury with the child's developmental capability.** When assessing an injury, consider whether the child is developmentally capable of causing the injuries. Also consider the child's size and ability to generate sufficient force to create the injury.

Remember that accidents do happen. Parents are not perfect. Injuries do occur that might have been avoided. However, abuse should be considered when injuries recur or the explanation is **inconsistent** with the injury or the child's developmental abilities.

Perinatal Substance Abuse

A woman's use of drugs during pregnancy does not constitute child abuse or neglect under West Virginia statutes. It is recognized, however, that pregnant women who use alcohol or other drugs risk their infant's normal health and development. The goal of the medical professional treating these women should be to help them bring the fetus to a healthy term by providing:

- Regular prenatal care.
- Basic health care advice, inclusive of information on the prevention of STD's and HIV.
- Nutrition advice.
- Information on substance use and the effects on the fetus.
- Referral to substance abuse treatment.

Infants exposed during gestation to alcohol and other drugs will need screening, developmental assessment, and monitoring to ensure the provision of medical care and support services.

Subsequent to birth, referral to Child Protective Services (CPS) should be considered if the child tests positive for alcohol or other drugs, if the child is having withdrawal symptoms, if the mother is not following medical recommendations thereby endangering the infant's health, or if substance abuse has interfered with her ability to meet the infant's basic needs.

Failure to Follow Treatment Recommendations

Failure of the parent or caretaker to provide needed health care is reportable to Child Protective Services to the extent that there is significant risk of illness, developmental delays, or imminent danger to the child's health.

Sexual Activity Between Children

Situations of sexual activity between children are reportable to Child Protective Services when:

- The perpetrator is in a caretaking role; or
- There is suspected lack of supervision by the parent or adult caretaker, thereby enabling the activity to take place.
- The parent knew or should have known that abuse was likely based upon previous behavior.
- The parent minimizes the incident or minimizes the threat of future occurrences.
- The parent does not appear to understand the abusive behavior

If there is any doubt about the parents willingness, and ability to protect the children from future harm, report the incident to Child Protective Services.

The following variables should also be considered when assessing sexual activity between children:

- Whether the activity is considered to be normal sexual curiosity that is developmentally appropriate.
- The age difference between the victim and perpetrator.
- The use of force or violence.
- The nature and frequency of sexual activity.
- The existence of a power differential, knowledge differential, and gratification differential between perpetrator and victim.

Children who perpetrate sexual assault against other children may themselves be victims. Child perpetrators should be referred for evaluation and treatment.

Perpetrators who are age 12+, engage in repetitive sexually exploitive behaviors, have multiple victims, use violence, or demonstrate other anti-social behaviors should be reported to the State Police or local law enforcement having jurisdiction for court supervision and services.

“The most effective kind of education is that a child should play amongst lovely things.”

~ Plato



3. Reporting Child Abuse and Neglect

Why Should I Report?

The purpose of required reporting is to identify suspected abused and neglected children as soon as possible so that they may be protected from further harm. Child Protective Services cannot act until a report is made. Consequently, as health professionals, you play a critical role in preventing any future harm to children.

Without detection, reporting, and intervention, these children may remain victims for the rest of their lives. Abused children don't just grow up and forget their childhood. They carry physical and emotional scars throughout their lives, often repeating the pattern of abuse or neglect with their own children.

Health professionals can help stop the cycle of abuse and neglect.

Who Must Report?

Anyone may report abuse or neglect; however, under West Virginia law, certain professionals are required to report. These professionals include:

- **medical, dental or mental health professionals.**
- Christian Science practitioners.
- religious healers.
- school teachers and other school personnel.
- social service workers.
- child care or foster care workers.
- emergency medical services personnel .
- peace officers or law enforcement officials .
- humane officers.
- members of the clergy.
- circuit court judges, family court judges, magistrates or employees of the Division of Juvenile Services.
- youth camp administrator or counselor.
- employee, coach or volunteer of any entity that provides organized activities for children.
- commercial film or photographic print processor.

As a result of Senate Bill 161 (effective June 8, 2012), ANY person over 18 who receives a disclosure from a credible witness or observes any sexual abuse or sexual assault of a child shall report to Child Protective Services or the State Police or other law enforcement agency having jurisdiction.

Liability of the Reporter

West Virginia law provides immunity from civil or criminal liability for persons reporting abuse in good faith [WV Code 49-6A-6].

Penalty for Failure to Report

Under West Virginia law, any required reporter of suspected abuse who knowingly fails to report shall be guilty of a misdemeanor. Penalties include up to 30 days in jail and/or a \$1,000 fine [WV Code 49-6A-8].

Besides the legal consequences of failing to report, consider the emotional consequences. Will you be able to live with yourself if you know you didn't do everything possible to protect a child from harm?

When to Report

Any time you suspect that a child is being abused or neglected or observe a child being subjected to conditions likely to result in abuse or neglect, you are required by law [WV Code 49-6A-2] to report your concerns to the local Child Protective Services (CPS), immediately, and not more than 48 hours later.

Furthermore, if you believe a child has suffered serious physical abuse or has been sexually abused or sexually assaulted, you must also immediately report your concerns to the State Police AND to any local law enforcement agency having jurisdiction to investigate the complaint [WV Code 49-6A-2].

You need not prove that abuse or neglect has taken place; personnel from local CPS are responsible for making this determination. Your responsibility is to alert them to your suspicions.

How to Report

When you suspect that a child is being abused or neglected, you should report your concerns to the Child Protective Services division of the state Department of Health and Human Resources (DHHR) in your community [WV Code 49-6A-5]. Local offices are open during daytime business hours and their telephone numbers are located in Appendix 9A.

Reports can also be made to the Child Abuse and Neglect Hotline (1-800-352-6513), 7 days a week, 24 hours a day.

When making a report, it is helpful to provide as much information as possible, if known. Information you may be able to provide includes:

- the name, address, and telephone number of the child and parents or other person(s) responsible for the child's care.
- the child's birthdate or age, sex, and race.
- a description of the nature of the injuries or condition.
- history of prior injuries or maltreatment of the child or siblings.
- reasons for suspecting abuse or neglect.
- geographic location that the suspect abuse occurred
- medical services needed.
- the names and ages of other persons who live with the child and their relationship to the child.
- the name, address, and telephone number of the suspected abuser and his/her relationship to the child.
- any other pertinent information.
- your name, address and phone number.

Informing the Parents of the Report

As a health care provider, you have a professional relationship with the child and/or parents; however, be cautious about discussing the report to Child Protective Services with the parents. You do not want to place the child at further risk or interfere with the CPS and law enforcement investigations.

If you choose to inform the parents, it is important that you be honest. Often parents will respect you for your honesty even though they may disagree with the position you've taken. You should explain that medical professionals are required by law to report all cases of neglect or injury to children caused by questionable or other than accidental means. The law does not give you a choice about reporting.

“There are no seven wonders of the world in the eyes of a child. There are seven million.”

~Walt Streightiff



Filing a report of suspected child abuse or neglect can be described as making a referral for services on behalf of the child and family. The intent of a report is to protect the child from further harm and to improve family relationships. Medical professionals should reassure the parents of their continued availability and belief in the intervention process.

What if I'm Not Sure?

You may consult with your local Child Protective Services or with staff at the Child Abuse and Neglect Hotline.

Be aware how your own biases may affect your decision about whether a particular injury or behavior is reportable. For example, will you be more likely to report a suspicious bruise on a child who lives in poverty than on a child from an upstanding family of the community?

If a child has shared information with you about abuse or neglect, this is enough for you to make a report. It is better to make your concerns known than to remain silent and possibly allow a child to remain unprotected.

What if the abuse occurred in the past?

Any case of suspected child abuse or neglect where the victim is under 18 must be reported even if the abuse or neglect occurred in the past. The Child Protective Services worker will evaluate the situation to determine whether an investigation is warranted at the time of your report.

What if a report is not accepted by Child Protective Services?

Reports not alleging a child has been abused or neglected as defined in West Virginia State Statute 49-1-3 will not be investigated by Child Protective Services. The reporter may be given information on other resources that can assist the family. When a child has allegedly been abused by someone other than the parent, guardian or custodian, CPS may not investigate the report but will forward the report to the appropriate law enforcement agency.

CPS will notify any mandated reporter of whether an investigation has been initiated and when the investigation is completed [WV Code 49-6A-2a]. If a decision is made not to investigate, and you disagree, you may further discuss your concerns with the CPS supervisor. When a case is not appropriate for CPS, you may ask for suggestions or guidance in dealing with the family.

“If our American way of life fails the child, it fails us all.”

~ Pearl S. Buck



4. Issues and Concerns about Reporting

A report of suspected maltreatment is not an accusation. It is a request for services on behalf of the child and family. The reporting process, however, may not always go smoothly. Difficulties may be encountered that can act as a barrier to reporting or can discourage continued involvement in situations of child abuse and neglect. Some of these difficulties are discussed in this chapter.

Previous Experiences

Health professionals who have had an unsatisfactory experience when reporting suspected child abuse or neglect may be reluctant to report a second time. These professionals may have been discouraged from reporting, or may have developed a distrust of Child Protective Services, feeling that a previous case was not handled to their satisfaction. These concerns are real. Things may not have gone as well as they could have. A previous bad experience, however, does not mean that the next time things will not be handled well. If you have an unsatisfactory experience with a CPS response, you should consider requesting intervention by a supervisor in the handling of the case.

The Belief that Nothing will be Done

Sometimes potential reporters are convinced that nothing will be done if they report, so they don't report. Aside from the legal considerations (failure to report is illegal in West Virginia), such reasoning is faulty. If an incident of suspected child abuse or neglect is reported, some action will occur. At the very least, reporting ensures that CPS is made aware of your concerns and your legal obligation is fulfilled. On the other hand, if the incident is not reported, nothing will be done. Abused and neglected children cannot be protected unless they are first identified, and the key to identification is reporting.

Physician-Patient Privilege

The statutory duty to report is not excused by the confidentiality of physician-patient privilege. It is important to recognize that the child, not the parent, is your patient. Your professional obligation is to the child's wellbeing. Issues surrounding the parents and their best interests are secondary.

“Every child born
into the world is
a new thought of
God, an ever fresh
and radiant
possibility.”

~ Kate Douglas Wiggin

West Virginia's child abuse and neglect reporting statutes are no different than those statutes that require the reporting of certain infectious diseases; in both instances, the overriding interest of individual safety limits the physician-patient right of confidentiality.

Risk Management

Most health professionals will encounter cases of child abuse and neglect in their practices. The assessment of abuse and neglect is no different than the assessment of any other pediatric illness. The health professional's responsibility to the patient is the same and the diagnostic evaluation must be approached in the same logical manner.

Ray E. Helfer, M.D. compared child abuse and neglect to cystic fibrosis, diabetes, or any other familial disease. Child abuse and neglect is a family problem and must be approached in the same sequential manner used with all other serious medical conditions that run in families.

In general, doing what is medically best is good risk management. Specialists must adhere to the standards of their specialty. In diagnosing and treating suspected child abuse or neglect health professionals should:

- have knowledge of child abuse and neglect reporting laws.
- be aware of the battered child syndrome.
- be aware of the medical and behavioral indicators of abuse and neglect.
- be aware of at-risk populations.
- arrange for physical examinations, evaluation, and interviews, as appropriate.
- get a second opinion in unclear situations.
- provide for follow-up care.



“The child must know that he is a miracle,
that since the beginning of the world there
hasn’t been, and until the end of the world
there will not be, another child like him.”

~ Pablo Casals



5. Medical Evaluation Plan

Physical examination

A thorough physical examination should be performed on every child suspected of being physically abused or neglected. The goals of the examination should be to:

- identify trauma or conditions requiring medical attention.
- document evidence of abuse or neglect.
- provide assurance to the child and/or parents concerning the course of treatment.

In situations of suspected child sexual abuse where the last sexual contact occurred within 72 hours of examination, physical evidence should be collected utilizing the Physical Evidence Recovery Kit (PERK) available at most hospital emergency rooms or from local law enforcement.

Photographs

A CPS worker, in the course of an investigation of reported child abuse, may take photos of the child, yard, home and car without the permission of the parent or guardian. [WV Code 49-6A-4]

Medical Documentation of Child Abuse and Neglect

Comprehensive documentation is essential to the management of these cases. Medical documentation supports the diagnosis, enables the CPS worker to make an informed and accurate case disposition, and provides evidence in the event of judicial proceedings. In addition, a well documented medical record may eliminate or reduce the amount of time a physician may be required to spend in judicial proceedings.

Comprehensive medical documentation of child abuse and neglect includes:

- Body charts or photographs.
- Description of the injury(ies) including:
 - Location.
 - Size.
 - shape (resembles instrument used?).
 - color.
 - dates of bruise(s) or fracture(s).
- X-ray results.
- Laboratory results.
- Results of physical examination.
- Medical history referencing previous injuries, conditions, or hospitalizations.
- Length of time between injury and obtaining medical treatment, if significant.
- Statements made by **child** concerning cause of injury and sequence of events; direct quotes should be used so that the history accurately reflects the child's level of understanding.
- Statements made by **parents** or **caregiver** concerning the cause of injury and sequence of events.
- Whether the explanation seems vague or confused.
- Consistency of the injury (nature, severity, and location) with explanation provided.
- Consistency of the injury with child's developmental abilities.
- Presence of other unexplained injuries.
- Treatment recommendations.

Release of Medical Records to Child Protective Services

During the course of a child abuse or neglect investigation, the Child Protective Services worker may request the release of medical records.

West Virginia Code 49-6A-9(e) authorizes medical professionals to release any records or reports that document the basis for the report of suspected abuse or neglect. The medical professional is responsible for determining which records are necessary for release to CPS.

“Be gentle with the young.”

~Juvenal



Parents, the child, and legal counsel may exercise their right to see all personal information contained in the CPS case record [WV Code 49-7-1]; however, the individual requesting information is only given access to that portion of the record concerning him or herself. Safeguards are taken to ensure the confidentiality of other persons mentioned in the CPS case record, including the identity of the reporter.

“What feeling is so nice as a child’s hand in yours? So small, so soft and warm, like a kitten huddling in the shelter of your clasp.”

~Marjorie Holmes



6. Responding to the Child Victim

How to Respond to the Child Who Reports Being Abused or Neglected

When a child tells you, openly or indirectly, about abuse or neglect, it is important to recognize the strength which this child has demonstrated by sharing the secret, as well as the trust the child has shown you by choosing you as a confidante.

Although it may be a difficult subject for you to discuss, it is important that you handle the disclosure with sensitivity. These general guidelines can help:

- Listen to what is being told to you. Do not push the child to share more than he/she is willing. The child needs warmth and acceptance. It is not necessary at this time that intimate details be revealed.
- Do not ask direct questions of the child—this might compromise the investigation.
- Reassure the child that he/she has done the right thing by telling you. Acknowledge the difficulty of the decision and the personal strength shown in making this decision. Make it clear that the abuse or neglect is not the child's fault and that the child is not bad or to blame.
- Keep your own feelings under control. Be calm and non-judgmental. Be careful not to criticize or belittle the child's family.
- Use the child's own vocabulary.
- Do not promise not to tell. Know your limits. This is not a situation you can handle by yourself. However, do not discuss what the child told you with anyone who is not directly involved in helping the child.
- Tell the truth. Don't make promises you can't keep, particularly relating to secrecy, court involvement, placement and social worker decisions.
- Be specific. Let the child know exactly what is going to happen. Tell the child that you must report the abuse or neglect to Child Protective Services. Tell the child that a social worker who helps families with these kinds of problems may be coming to talk with the child.

- Assess the child's immediate safety. Is the child in immediate physical danger? Is it a crisis? Are there others in the home who can protect the child?
- Be supportive. Remember why the child came to you.

The child needs your help, support and guidance. Reassure the child that telling about the abuse or neglect was the right thing to do. It is the only way to make it stop.

When a child tells you that he or she has been abused, the child may be feeling scared, guilty, ashamed, angry and powerless. You may feel a sense of outrage, disgust, sadness, anger and sometimes disbelief. It is important for you to remain calm and in control of your feelings in order to reassure the child.

Try to help the child regain control. The child is about to become involved in a process in which the primary intent will be to determine the child's best interest. At times, this may seem to sweep the child up in a series of events that are beyond control. Although alternatives may be limited, it can help to let the child make decisions, whenever possible, to allow the child some sense of self-determination. For example, you might ask the child what you can do to help or make the process less difficult.

Techniques for interaction with the abused or neglected child

The following are tools or techniques that can be used by health professionals with children who report abuse or neglect:

- Never underestimate the power that a positive adult relationship can have in a child's life. Children take their cues from adults.
- Ask permission before touching, again allowing a child to regain control.
- Don't speak badly of the abuser. The abuser is often known and liked or loved by the child. Suggested statements:

“What he/she did to you was wrong — I am sorry that it happened to you.” “It was unfair of him/her to do that to you. I am sorry that it happened.”

“Listen to the mustn’ts, child. Listen to the don’ts.
Listen to the shouldn’ts, the impossibles, the won’ts.
Listen to the never haves, then listen close to me...
Anything can happen, child. Anything can be.”

~Shel Silverstein



- Try not to act shocked, angry or upset at what a child may say or do. Remain open for more information. Suggested statements:

“I’m sorry that happened to you. We need to tell someone so that (abuser’s name) can get help to stop doing that to you.”

- Do not make a child feel different or singled out. Treat the child just like every other child, but with an extra dose of compassion.
- Use your colleagues as resource people and for support, keeping in mind the child’s right to privacy.

“Many people will walk in and out of your life, but only true friends will leave footprints in your heart.”

~Eleanor Roosevelt



7. Child Protective Services' Response

What Happens After You Make a Report

When a report of suspected child abuse or neglect is made, Child Protective Services staff must determine whether the situation described meets the legal definition of child abuse or neglect and whether CPS has the authority and responsibility to investigate. If not, the report is screened out. If so, the report is assigned.

CPS has two categories of workers: initial assessment and treatment. Initial Assessment CPS workers receive and investigate reports of abuse and neglect and make a finding as to whether or not maltreatment occurred. Treatment CPS workers work with families whose cases are opened for further services and cases which go to court.

The Investigation

West Virginia law requires that in a report of imminent danger, a face-to-face interview with the child and the development of a protection plan must be made within 72 hours. In all other reports, a face-to-face interview with the child and the development of a protection plan must occur within 14 days [WV Code 49-6A-9].

The CPS worker will interview the child, siblings (if necessary), the parents or caretakers, the alleged abuser, and any other people having information about the incident. The worker may come to the provider to interview or observe the child. It's important to note that CPS workers do NOT need the parents' consent to interview the child [WV Code 49-6A-9(b)(3)].

Through interviews, observation, and information gathering, the CPS worker will, within 30 days, make a finding about:

- (1) whether or not maltreatment occurred.
- (2) whether the child is safe.

West Virginia law requires that in a report of imminent danger, a face-to-face interview with the child and the development of a protection plan must be made within 72 hours.

Right to Appeal Investigative Findings

Individuals who have an investigation finding made about them have the right to file a grievance. They may obtain forms from their local Department of Health and Human Resources office.

Services Provided to Family

While the immediate objectives of an investigation are to gather the facts and protect the child from immediate harm, these are not the only objectives. The CPS worker is also responsible for helping the parents identify and solve the problems that may have caused maltreatment. The CPS worker helps the parents acquire the knowledge and skills needed to provide adequate care for their children.

Services are provided to the family by the CPS worker and community agencies. These services may include: individual or family counseling; parenting groups or classes; homemaker services; respite day care; or family supervision provided through home visits by the CPS worker or another agency.

The length of time that CPS provides services to a family varies from case to case and is dependent on the continued risk of harm to the child.

Feedback from Child Protective Services

Intrusion into family life to protect a child is a highly sensitive matter requiring confidentiality. Due to strict federal and state laws concerning the release of Child Protective Services information, the CPS worker is restricted in the information that can be discussed with individuals outside of the family [WV Code 49-7-1].

The CPS worker is permitted to disclose information to medical professionals when it is in the best interests of the child. At a minimum, you will be informed that a report has been investigated and determined to be unsubstantiated or that necessary action has been taken.

If you are not contacted by the CPS worker within 45 days of the date of the report and you wish to learn the outcome of the investigation, you may call the worker assigned to the case or the supervisor.

Multi-Disciplinary Teams (MDT)

In 1995, a system was established for evaluation of and coordinated service delivery for children who may be victims of abuse or neglect and children undergoing delinquency proceedings, known as multi-disciplinary teams [WV Code 49-5D]. The Investigative MDT, headed by the prosecuting attorney, is responsible for coordinating the initial and ongoing investigation of all civil and criminal allegations pertinent to cases involving child abuse [WV Code 49-5D-2].

If the case goes into court, a Treatment MDT will be formed to assist the court in facilitating permanency planning, to recommend alternatives, and to coordinate evaluations and in-community services. Members may participate by telephone or video conferencing.

Rules of confidentiality do not apply within the MDT, allowing for full and appropriate sharing of information. MDT members are bound by laws of confidentiality not to release information beyond the MDT and, if applicable, the court [WV Code 49-5D-3].

If you wish to participate in a Treatment MDT for a particular child, notify the CPS worker of your interest.



“From caring
comes courage.”

~Lao Tzu

“If you can give your son or daughter
only one gift, let it be enthusiasm.”

~ Bruce Barton



8. When Cases go to Court

Civil Court Action and Testimony by Medical Professionals

Most cases of child abuse or neglect do not require court involvement. Most families will accept help in correcting the circumstances that caused the maltreatment. However, when there is evidence of abuse or neglect and the family does not do what is necessary to ensure the child's safety, a petition may be filed in circuit court by Child Protective Services or by any responsible adult [WV Code 49-6-1]. The court is a place where the rights of the child and the parents are protected. Ultimately, the court will decide what is in the best interests of the child.

Medical professionals may be requested to provide written reports or testimony to assist the court in making a decision. Well documented medical reports **may** eliminate or reduce the amount of time spent in judicial proceedings.

In those instances when medical professionals are called to testify, you will testify either as a factual witness or an expert witness. If you are a factual witness, you will be asked questions related to what you observed and your conversations with the child. If you are an expert witness, you will be asked to give an opinion on whether the explanation is consistent with the findings.

If you are asked to testify, you should contact the attorney calling you as a witness to request the following:

- the status of the case and the type hearing to which you have been subpoenaed.
- the nature and the extent of the evidence you will be asked to provide.
- the date, time, and place that you actually need to appear (ask to be placed "on call" so that the waiting time is minimized and you will have to be at the courthouse only when you are actually needed.)
- whether you have a choice about talking with the attorney for the other side before the hearing and how to deal with requests to do so.
- whether other medical professionals are involved in the case.
- a pre-trial conference or preparation by the attorney presenting you as a witness. (Take the opportunity to educate the attorney on the scope and limits of medical knowledge related to the injury.)

The purpose of West Virginia’s child welfare laws is to assure the spiritual, emotional, mental and physical well-being of the child and to preserve and strengthen the child’s family ties, when possible. In all cases, the goal is to assure the child a safe and permanent home.

Legal Procedures

The purpose of West Virginia’s child welfare laws is to assure the spiritual, emotional, mental and physical well-being of the child and to preserve and strengthen the child’s family ties, when possible. In all cases, the goal is to assure the child a safe and permanent home.

Child Protective Services is required to address the safety, permanency and well-being of children who are abused and/or neglected. CPS will try to prevent the removal of the child if the child’s safety in the home can be assured. If there are aggravated circumstances, or if the child’s safety in the home cannot be assured, CPS will petition the court in order to assure children in the home are protected.

Removal and placement is traumatic for the child. The child often feels abandoned by the family and can even feel responsible for the problems in the home that led to removal. Removal can lead to feelings of insecurity as the child wonders if the family will ever be reunited. In addition, the child must adjust to a new family—and possibly even a new school or community.

If it becomes necessary to remove the child, the CPS worker will give the parents or guardian an opportunity to place the child with relatives in order to preserve a sense of family identity. When this is not possible, placement in foster care or in group care may be necessary. The ultimate goal is to assure that the child is placed in a safe, secure and permanent home. If the family can be reunited safely, then this option has priority.

* Aggravated circumstances include but are not limited to abandonment, torture, chronic abuse, sexual abuse, murder of another child or the child’s other parent, voluntary manslaughter, attempted or conspired to commit murder or accessory before or after the fact, and felonious assault resulting in serious bodily injury.

What Happens in Cases of Abuse and Neglect?

This section provides a brief description of the procedures set forth in West Virginia law for cases of child abuse or neglect [WV Code 49-6].

In certain instances, West Virginia law permits Child Protective Services and law enforcement officers to take a child into immediate protective custody for the protection of the child [WV Code 49-6-9]:

- A CPS worker may take immediate emergency custody of a child in an emergency situation that constitutes imminent danger to the physical well-being of the child if the worker has probable cause to believe that the child will suffer additional abuse or neglect or will be removed from the county before a petition can be filed and temporary custody ordered.
- A law enforcement officer may take a child into protective custody for up to 96 hours without a court order if the child has been abandoned or requires emergency medical treatment and the parent is absent or refuses to permit the treatment.

Whether protective custody has been taken or not, the next step is a child abuse and/or neglect petition. The petition is usually filed by the CPS worker, and it alleges the specific abusive or neglectful conduct, including time and place, and explains how such conduct comes within the statutory definition of abuse or neglect. The petition details any supportive services provided by CPS to remedy the alleged circumstances, and explains the relief sought. After the petition is filed, the Circuit Court must set a hearing and appoint counsel. (If a temporary custody order is in effect, this hearing must be scheduled within 30 days).

The Circuit Court may grant temporary emergency custody to the West Virginia Department of Health and Human Resources (DHHR) or to a responsible relative for not more than 10 days pending a preliminary hearing if the child is in imminent danger and there are no reasonable alternatives to removing the child from the home. (Reasonable alternatives might include medical, psychiatric, psychological, or homemaking services for the family while the child remains in the home but in the state's custody.)

If the alleged abuser is a member of the household, the child may not remain in the home unless the abusing person is removed by court order. Other children in the home are included in the custody issue whether it is alleged they have been abused or not. They may be removed temporarily if the court finds imminent danger and a lack of reasonable alternatives to removal. If one child is in imminent danger, then all children in the home are presumed to be.

The next step is a preliminary hearing. If the court finds that continuation in the home is contrary to the best interests of the child, it may grant custody to the DHHR or a responsible relative or other appropriate agency or person temporarily.

At this time, the court may also grant an improvement period for the parent or custodian for a period of months to try to remedy the circumstances that led to the petition of abuse or neglect, if the parent or custodian proves by clear and convincing evidence that he or she will fully participate in such an improvement period. If allowed, a family case plan is developed by CPS and the multidisciplinary treatment team (MDT) that details services to be provided to the family and lists specific, measurable, realistic goals to be achieved by the parent or custodian.

At the end of the improvement period (if one is granted), there is an adjudicatory hearing. The court makes a determination as to whether the child has been abused or neglected. The parent or custodian may seek a post-adjudicatory improvement period. After adjudication, the child's case plan will be developed.

Finally, there is a dispositional hearing [WV Code 49-6-5]. The court may:

- dismiss the petition.
- refer the child, the battered parent, abusing parent(s) or other family member(s) to a community agency and dismiss the petition.
- return the child to the home under supervision of the CPS.
- order terms of supervision to assist the child and abusing parent(s) or battered parent.
- upon finding the abusing parent(s) or battered parent unwilling or unable to provide adequately for the child's needs, commit the child to the temporary custody of the state, department, licensed welfare agency, or suitable guardian.
- in some cases, grant another improvement period of not more than 6 months with a possible 3-month extension.
- terminate the parental rights of a child who has been in foster care for 15 of the last 22 months unless there are compelling reasons not to do so.

If the court decides there is no reasonable likelihood that the conditions of abuse or neglect can be substantially corrected in the near future, and when necessary for the welfare of the child, the court will terminate parental, custodial or guardianship rights and commit the child to permanent sole custody of the non-abusing parent (including a battered parent), if there is one, or terminate parental, custodial or guardianship rights and commit the child to the guardianship of the DHHR or a licensed child welfare agency. The court will not terminate parental, custodial or guardianship rights if a child, age 14 or older, objects.

At each step in the legal process, the court is concerned with the safety and best interests of the child, and if possible, preserving and reunifying the family.

Cooperation with a Court Appointed Special Advocate (CASA)

In West Virginia, judges in communities where there is a CASA program have been able to appoint a Court Appointed Special Advocate for a child involved in civil child abuse proceedings. The CASA is a volunteer from the local community who has been trained to advocate for the best interests of a child who has come into the court system as a result of abuse or neglect.

The CASA volunteer, acting under order of the court, reviews records; facilitates prompt, thorough review of the case; and interviews appropriate parties to make recommendations on what would be in the best interests of the child.

The CASA volunteer respects the right to privacy by keeping information confidential that would identify parties involved in CASA cases.

If you are the medical provider to a child in DHHR custody, you may be contacted by the CASA volunteer for information. You should request to see the volunteer's identification and a copy of the court order appointing the CASA to the case before providing information. The CASA would also appreciate being contacted about any significant developments relating to the child. The better the information, the more effective the CASA can be in advocating for the child's best interest in any legal proceedings.

There are CASA programs in various locations around the state. To see if there is a CASA program in your area, contact the West Virginia CASA Association at www.wvcasa.org.

Criminal Prosecution

Child Protective Services is required to report all cases of serious physical abuse and all cases of sexual abuse and sexual assault to the county prosecuting attorney's office. Criminal prosecution is at the sole discretion of the prosecutor.

At each step in the legal process, the court is concerned with the safety and best interests of the child, and if possible, preserving and reunifying the family.



“Children are the hands by which we
take hold of heaven.”

~ Henry Ward



9. Appendices

A: State and National Resources

B: WV Department of Health and Human Resources Offices

C: Child Protective Services Referral Form

D. Mandated Reporter Disclosure Aid

E. What Can Be Done To Prevent Child Abuse
About TEAM for West Virginia Children

APPENDIX A

State and National resources

National Resources

American Academy of Pediatrics

<http://www.aap.org>

Centers for Disease Control & Prevention, Child Maltreatment Prevention Page

<http://www.cdc.gov/violenceprevention/childmaltreatment/>

Child Find of America Hotline

<http://www.childfindofamerica.org>
1.800-I.AM.LOST

Child Help National Child Abuse Hotline

<http://www.childhelp.org/hotline>
1.800.426.5678

Darkness to Light

<http://www.d2l.org>
1.866. FOR.LIGHT

National Center for Missing and Exploited Children

<http://www.missingkids.org>
1.800.843.5678

National Alliance of Children's Trust & Prevention Funds

<http://www.ctfalliance.org>

National Court Appointed Special Advocate Association

<http://www.casaforchildren.org>
1.800.628.3233

National Domestic Violence Hotline

<http://www.thehotline.org>
1.800.799.SAFE or 1.800.799.7233

Prevent Child Abuse America

<http://www.preventchildabuse.org>
1.800.CHILDREN or 1.800.244.5373

Runaway Switchboard

<http://www.1800runaway.org>
1.800. RUNAWAY or 1.800.786.2929

West Virginia Resources

Mountain State Parents, Child, Adolescent Network (CAN)

www.mspscan.org
1.800.CHILD85 or 1.304.233.5399

Our Babies: Safe and Sound

<http://www.safesoundbabies.com>

Prevent Child Abuse West Virginia

<http://www.preventchildabusewv.org>
1.866.4KIDSWV

TEAM for West Virginia Children

<http://www.teamwv.org>

West Virginia Child Advocacy Network

<http://www.wvcn.org/>
304.414.4455

West Virginia Advocates

<http://www.wvadvocates.org>
1.800.950.5250

West Virginia Child and Adult Abuse Hotline

1.800.352.6513

West Virginia Child Care Association

<http://wvcca.org>
304.340.3611

West Virginia Children's Trust Fund

<http://www.wvctf.org>
304.558.4637

West Virginia Coalition Against Domestic Violence

<http://www.wvcadv.org>
304.965.3552

West Virginia Court Appointed Special Advocate Association

www.wvcasa.org

West Virginia Court Improvement Program

www.wvcip.com

West Virginia Department of Health and Human Resources Bureau for Children and Families

www.wvdhhr.org/bcf

Bureau for Child Support Enforcement

www.wvdhhr.org/bcse

Bureau for Public Health, Office of Maternal, Child and Family Health

www.wvdhhr.org/mcfh

Child Abuse Prevention Page

www.wvdhhr.org/bcf/children_adult/ca-buseprev/default.asp

West Virginia Healthy Kids and Families Coalition

www.wvhealthykids.org

West Virginia Kids Count Fund

www.wvkidscountfund.org
1.888. KIDSCOUNT

West Virginia Legislature's Office of Reference and Information

www.legis.state.wv.us
1.877.565.3447

West Virginia Mental Health Consumers Association

<http://www.mhca.org>
304.345.7312

West Virginia State Bar Legal Information Service

http://www.wvbar.org/public_information/
1.800.642.3617

APPENDIX B

Local Offices of the W. Va. Department of Health and Human Resources

Barbour	304-457-9030	Mineral	304-788-4150
Berkeley	304-267-0100	Mingo	304-235-4680
Boone	304-369-7802	Monongalia	304-285-3175
Braxton	304-765-7344	Monroe	304-772-3013
Brooke	304-794-3060	Morgan	304-258-1350
Cabell	304-528-5800	Nicholas	304-872-0803
Calhoun	304-354-6118	Ohio	304-232-4411
Clay	304-587-4268	Pendleton	304-358-2305
Doddridge	304-873-2031	Pleasants	304-684-9244
Fayette	304-465-9613	Pocahontas	304-799-2540
Gilmer	304-462-0412	Preston	304-329-4340
Grant	304-257-4211	Putnam	304-586-1520
Greenbrier	304-647-7476	Raleigh	304-256-6930
Hampshire	304-822-6900	Randolph	304-637-5560
Hancock	304-794-3060	Ritchie	304-643-2934
Hardy	304-538-2391	Roane	304-927-0956
Harrison	304-627-2295	Summers	304-466-2807
Jackson	304-373-2560	Taylor	304-265-6103
Jefferson	304-724-2600	Tucker	304-478-3212
Kanawha	304-746-2360	Tyler	304-758-2127
Lewis	304-269-6820	Upshur	304-473-4230
Lincoln	304-824-5811	Wayne	304-272-6311
Logan	304-792-7095	Webster	304-847-2861
McDowell	304-436-8302	Wetzel	304-455-0920
Marion	304-368-4420	Wirt	304-275-6551
Marshall	304-843-4120	Wood	304-420-2560
Mason	304-675-0880	Wyoming	304-732-6900
Mercer	304-425-8738		

Child Protective Services Referral Form

Mother's Name _____ Birth Date _____

Address _____ Phone _____

Father's Name _____ Birth Date _____

Address _____ Phone _____

Other adults in the home:

Name _____ Relationship _____ Birth Date _____

Name _____ Relationship _____ Birth Date _____

Child(ren) involved:

Name _____ Birthdate _____ Sex _____ Race _____

Name _____ Birthdate _____ Sex _____ Race _____

Name _____ Birthdate _____ Sex _____ Race _____

Please list a family member who can protect the child, if one is available:

Provide a brief but accurate description of the abuse and/or neglect including the abuser's name:

Information about the child(ren)s' current condition:

APPENDIX D

Mandated Reporter Disclosure Job Aid

What to do when a child or adult discloses suspected child abuse or neglect.

1. Find a private place to talk with the person.
2. Reassure the person making the disclosure (“I believe you.”)
3. Listen openly and calmly, with minimal interruptions.
4. Write down the facts and words as the person has stated them.
(Exact words are important to investigators.)
5. Do not promise not to tell, but respect the person’s confidentiality by not telling others who don’t need to know.
6. Tell the truth.
7. Be specific. Let the child know what is going to happen.
8. Assess the child’s immediate safety.
9. Be supportive.
10. Report the disclosure immediately and no later than 48 hrs to CPS.

What NOT to say when someone discloses suspected child abuse or neglect.

1. Don’t ask “why” questions such as: “Why didn’t you stop him or her?” “Why are you telling me this?”
2. Don’t say “Are you sure?”
3. Don’t ask “Are you telling the truth?”
4. Don’t say “Let me know if it happens again.”
5. Avoid leading questions (“Did your uncle touch you too?” “Was he wearing a blue jacket?”)

WV Child Abuse and Neglect Hotline

1-800-352-6513 (24 hours a day, 7 days a week)

For serious physical abuse or sexual abuse,
also contact the state police & local law enforcement.

APPENDIX D

About TEAM for West Virginia Children

TEAM stands for “Together Eliminating Abuse and Maltreatment.” TEAM for West Virginia Children, a Huntington-based non-profit agency, formed in 1986, is dedicated to the prevention of child abuse and neglect. A small paid staff is helped by many volunteers to conduct programs including:

Western Regional Court Appointed Special Advocate (CASA) project provides trained community volunteers (CASA), appointed by a Circuit Court judge, to advocate for the best interests of an abused or neglected child who has been placed in state custody. The CASA fully researches the situation and makes recommendations to the judge on services needed and permanent placement for the child. The goal is a safe, permanent, loving home for the child.

Public awareness campaigns: The TEAM provides both speakers and materials to promote child abuse prevention. Specific materials are available to help prevent Shaken Baby Syndrome and promoting safe infant sleep through the Our Babies: Safe & Sound Campaign. The TEAM has developed a Train the Trainer curriculum and a series of booklets on identifying and reporting child abuse for mandated reporters.

Mountain State Healthy Families: This project provides voluntary intensive home visitor services for first-time parents who face many challenges. The goal is to help the family get off to a good start by promoting parent-child interaction, providing child development information, and serving as a link to needed community resources.

Prevent Child Abuse West Virginia (PCA-WV): This project is working to support safe and strong families through education, effective programs, and sound public policy. PCA-WV is a state chapter of Prevent Child Abuse America. Partners in Prevention is a statewide initiative of PCA-WV involving community teams around the state who are working to promote the well-being of children on a community level. PCA-WV is also leading efforts to build a network of Circle of Parents® mutual help support groups in West Virginia.

Partners in Community Outreach: This informal network of community-based In-Home Family Education programs around the state works together to build a statewide system of evidence-based early childhood home visiting programs that assures program quality and accountability - helping programs to improve child health; increase school readiness; enhance parenting skills and reduce child maltreatment.

To contact TEAM for West Virginia Children:

WEBSITES: teamwv.org • preventchildabusewv.org

PHONE: (304) 523-9587 • **FAX:** (304) 523-9595

ADDRESS: P.O. Box 1653, Huntington, West Virginia 25717-1653

EMAIL: team@teamwv.org

Twitter: <http://www.twitter.com/team4wvchildren>



“Childhood is the most beautiful of all
life’s seasons.”

~Author Unknown



TEAM for West Virginia Children

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