Governor’s Task Force on Justice for Abused Children

Standards for Connecticut Multidisciplinary Teams

Revised, 2008
# Standards for Connecticut Multidisciplinary Teams

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Standards for Connecticut Multidisciplinary Teams (Revised, 2007)

Child maltreatment is a community problem requiring community solutions. Multidisciplinary teams (MDTs) provide a coordinated inter-agency approach to enhance investigation and management of child sexual abuse and physical abuse cases. (C.G.S. Sec.17a-106a) Through a collaborative effort teams strive to accomplish the following goals:

- Ensure that prompt and appropriate actions are taken to assure the safety of the child victim,
- Reduce the trauma of victimization for the child,
- Minimize the number of required interviews for the child victim,
- Facilitate recommended medical and mental health services,
- Coordinate efforts in order to eliminate duplication of services,
- Increase the likelihood of successful prosecution of offenders,
- Provide support for non-offending parents in order to enhance their ability to protect and care for their children,
- Promote policies, practices and procedures that are culturally sensitive.

In order to achieve these goals, all team protocols shall adopt a common statement of purpose, as stated above and meet the following standards, with the understanding that team decisions cannot bind member agencies to provide specific services, but will serve as recommendations.

1) Referrals

Any team member may refer a case to the multidisciplinary team for review and consultation. Child protection (DCF), law enforcement or the State’s Attorney’s Office may refer a case for a forensic interview.

Cases may be considered for review by the team when the child/youth is under the age of 18 and is suspected of being a victim of:
- Sexual abuse
- Severe physical abuse
- Severe neglect
- Domestic Violence
- Death, due to abuse or neglect

2) Team Membership

Each multidisciplinary team shall consist of at least one representative of each of the following: (1) The State’s Attorney of the judicial district of the team, or his designee; (2) the Commissioner of Children and Families, or his designee; (3) the head of the local or state law enforcement agencies, or his designee; (4) a health care professional with substantial experience in the diagnosis and treatment of abused or neglected children, who shall be designated by the team members; (5) a mental health professional with substantial experience in the treatment of abused or neglected children, who shall be designated by the team members; (6) a team coordinator; (7) any other appropriate individual with expertise in the welfare of children that the members of the team deem necessary (C.G.S. Sec. 17a-106 a [b]). Other attendees/disciplines, which can be helpful to team operations include, but are not limited to representatives of Juvenile Prosecutor’s Office, Attorney General’s Office, Juvenile and Adult Probation, Family Services,
Youth Service Bureau, Sexual Assault Crisis Services, Domestic Violence Services, School Systems, DCF Attorneys, State Department of Education (in cases of school personnel involvement), and Department of Public Health Division of Community Based Regulation (in cases involving day care personnel).

3) Role of Team Members

Individual members serve as a liaison to his/her agency and will assume the following responsibilities:

1. Work to enhance a supportive interagency working relationship;
2. Attend scheduled team meetings or make arrangements for a designee to attend meeting, if necessary, or transmit relevant information if they are unable to attend;
3. Identify pending cases within his/her agency that would be appropriate for referral;
4. Update his/her agency administration or designee on essential information which will affect the functioning of that agency, as appropriate and when needed;
5. Orient/educate agency members, as possible and when appropriate, regarding team functioning and activities;
6. Encourage that his/her agency effectively and appropriately handles MDT cases;
7. Cross train team members;
8. Review agenda prior to meetings, prepare for and participate actively in meetings.

4) Team Leadership

A coordinator assumes the management and administrative responsibilities of the team, in addition to being an active member of the team. The responsibilities and time commitment of the coordinator may be jointly determined by the team and/or the funding agency. The coordinator should be selected by a collaborative process of the team members in consultation with the funding agency. This position is financially compensated at an equitable rate. The coordinator’s duties may include: schedule and facilitate meetings, record keeping, case tracking, schedule non-member participants at meetings, coordinate team development activities, maintain effective communications among members, regularly notify members of meeting agendas, distribute meeting summaries, arrange meetings to address administrative issues when necessary, and attend statewide coordinators’ meetings.

A team shall select or appoint a chairperson (C.G.S. 17a-106a [b]) whose duties and term of office will be determined by the team, and articulated in team protocols. A chairperson’s duties may include: arrange meetings to address administrative issues, act as a liaison between team and member agencies, outreach to non-member agencies, assume coordinator’s role in his/her absence, and represent the team in the community.

5) Attendance, Frequency of Meetings and General Team Functioning

Each team will designate a facility to conduct MDT meetings in order to coordinate services in cases of suspected child abuse.
Teams will establish regular meeting times which are mutually agreeable and can accommodate all team members. Each team will develop minimum attendance requirements for each core discipline, per state statute. Team meetings shall occur at least once monthly. Teams will meet for the purpose of case review and case tracking and will establish an efficient meeting process which permits all members to contribute and comment. Teams will establish a procedure by which member agencies can communicate and resolve concerns regarding the team and its work.

Team Protocols will reflect procedures for case review and case tracking; for timely attention to cases; and for effective communication with regard to children and families assessed/investigated by the team consistent with confidentiality limitations. Protocols will also include procedures for referrals for specialized medical evaluation and mental health therapy for child victims and their families as appropriate, which will be coordinated with the multidisciplinary response. Protocols will reflect how emergency/crisis services will be provided without regard to ability to pay. Protocols will also detail how referrals are made to appropriate facilities for victim and family support and advocacy throughout the investigation and prosecution of child abuse cases.

Teams shall conduct case tracking of child abuse cases reviewed, in accordance with state practice.

6) Investigations

Multidisciplinary teams will identify a designated child-appropriate, safe facility where all involved agencies have a place to interact with the child to conduct interviews.

Team investigations may include information from law enforcement, DCF, mental health, medical and victim services. Teams will promote forensic interviews which are of an objective, fact finding nature, and are coordinated to avoid duplicative interviews. Teams will strive to reduce the trauma of victimization to the child and family.

7) Confidentiality

Each team shall observe confidentiality as prescribed by state statute. All member and non-member attendees will be informed of confidentiality requirements. Pursuant to C.G.S. Sec.17a-106a (e) & (f), the multidisciplinary team shall have access to and may copy records of DCF and medical care providers. Confidential medical records may be obtained by the team coordinator in compliance with the statute.

Meeting participants shall not disclose information obtained at team meetings without the consent of the participant providing the information unless such disclosure is court ordered or required by other state statute.

8) Letter of Agreement

The head of each team member agency, or authorized designee, shall execute an annual written agreement to support the team, to improve the investigation, intervention, and prosecution of child abuse cases, according to protocols developed by the team.
9) **Documentation**

Each multidisciplinary team shall maintain records of meetings which will include, if known: names of victim and alleged perpetrator, names of team members and their positions, the decision or recommendation of the team and support services provided. Each team shall record case demographics and outcomes as established by state and/or federal guidelines. (C.G.S.17a-106 a [h])

10) **Team Development and Community Education**

Teams will provide cross training to member disciplines and encourage training opportunities in the field of child abuse to improve members’ knowledge base of each team member’s role, to increase skill sets in handling cases of child abuse and to increase cultural sensitivity to child abuse victims and their families. Teams will provide community education about child abuse to promote public awareness of child abuse and the team’s role in the community, and to promote professional education about child abuse.

11) **Networking and Statewide Activities**

Team Coordinators will actively participate in state chapter meetings to improve team functioning and to participate in other networking opportunities to enhance performance.

Teams will be encouraged to participate in voluntary statewide efforts to maintain and improve multidisciplinary teams.

1[1] C.G.S. Sec. 17a-106 a (f.)

2[2] C.G.S. Sec. 17a
Appendix: Best Practices* for Multidisciplinary Investigations and Assessments

Revised, November 2007

* Opinions or points of view expressed in this document represent a consensus of the Governor’s Task Force on Justice for Abused Children. Because practices continually evolve and because each victim and his/her situation is different, the GTF recognizes that its recommendations may not apply in all circumstances. These are neither mandates, nor policy directives. Rather they represent the GTF’s thinking of what constitutes best practices.
## Best Practices for Multidisciplinary Investigations and Assessments

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**Purpose of Multidisciplinary Investigations**

The purpose of a child abuse multidisciplinary investigation is to advance and coordinate the prompt investigation of suspected cases of child abuse or neglect, to reduce trauma to any child victim, to ensure the protection and treatment of the child and to prosecute, as necessary.

As used in this document, the term "team" refers to the entire multidisciplinary team defined in C.G.S. Sec. 17a-106a and not just those conducting the investigation. Investigation Unit (IU) refers to those members of a multidisciplinary team who conduct the investigation.

**Scope of Guidelines**

These guidelines are designed to provide suggestions for successful investigation. The handling of any particular investigation should be guided primarily by the goals of an investigation (see below) and the intent of the multidisciplinary team (see Standards for Multidisciplinary Teams), with the ultimate decisions determined by the appropriate IU member. Nothing in these guidelines is intended to create a basis for evidentiary standards or exclusionary motions regarding documentation or evidence. Deviation from the guidelines is not intended to limit the admissibility of any documentation or evidence in a court of law or other proceeding.

**Principles and Guidelines for Joint Investigations**

Consistent with the purpose of multidisciplinary investigations, joint investigations should be carried out by trained police and Department of Children and Families (DCF) investigators. All aspects of the investigation and assessment should be carried out by the best qualified person(s) available to the investigation unit and multidisciplinary team.

Goals of the joint investigation process are to
1. Gather evidence.
2. Keep investigative interviews and examinations of prospective child victims and witnesses to a minimum.
3. Maximize resources.
4. Avoid duplication of efforts.

**Investigation Unit (IU): Member Responsibilities**

The investigation of a child abuse complaint should be conducted jointly by trained individuals from law enforcement and DCF as an investigation unit (IU). While both are there to ensure the safety of the child, DCF social workers assess the risk of harm to the child in the future and are responsible for the ongoing protection of the child. Law enforcement officers are responsible for evaluating and, if warranted, gathering evidence for a criminal prosecution, i.e. to determine if a crime has been committed.
1. Department of Children & Families (DCF)iii
   The Department of Children and Families shall undertake all child protection investigative work, assess child safety and initiate action to assure such safety when necessary. DCF may coordinate all protection investigative work and rely upon information generated by the team.

2. Law Enforcement Officersiv
   The law enforcement officers involved shall undertake all criminal investigative work and may coordinate investigative work and rely upon information generated by the team.

3. Additional Investigation Unit Membersv
   Team members or others may be included as part of the IU, such as a forensic interviewer and/or a medical care provider, depending on the individual case.

The protocols, procedures and standards of any IU shall not supersede the protocols, procedures and standards of the agencies on the multidisciplinary team. vi

Initial Response and Investigationvii

Effective coordinated child abuse investigations include a response developed prior to a complaint being acted upon. A team should establish a protocol for IU response to child abuse complaints in their jurisdiction.viii

The following procedures should be considered in such a protocol:

1. Response to complaints if received during normal business hours versus after business hours and on the weekend;
2. Identification of responsibilities within an individual investigation regarding such issues as making contact with other investigators and assignment of responsibilities for tasks such as witness interviews, gathering of evidence, etc.;
3. Recognition that DCF has a mandate to complete investigations in 30 days, a coordinated plan should be developed between DCF and the police to interview the suspected perpetrator and all other relevant witnesses with respect to allowable and respective time frames;
4. Method for sharing gathered information;
5. Plan for removal of suspected perpetrator from home of child victim;

Protocols should address: (1) a prompt initial response, (2) contact with the initial reporter, (3) clarification of information regarding the circumstances of the complaint, and (4) identification of child’s disclosure regarding the abuse.

Other adults and non-victim witnesses may need to be interviewed and information documented. The investigators decide which potential witnesses will be interviewed and how those interviews are to be conducted and documented. Typical witnesses include:
1. The first person to whom a child victim made disclosure and others to whom the child has disclosed;
2. The non-offending caregiver or guardian;
3. Medical responders including ambulance personnel;
4. The suspected perpetrator;
5. Other family or household members, including children; and
6. Other relevant individuals.

Prior history checks of both DCF and police records should be conducted in appropriate cases.

Consideration should be given to the applicability of Family Violence statutes.\textsuperscript{x}

**Crime Scene Documentation and Corroboration**

Documentation of the crime scene and the recovery of corroborating evidence need to be considered. The timing of this should be determined on a case by case basis, though immediate action is often necessary to preserve a scene or evidence.

Efforts should be made to document applicable crime scenes and to corroborate information disclosed by witnesses. This may include the use of photographs, measurements, tangible objects, crime scene diagrams and other records.

Examples might include wall decorations disclosed by a child in a room where the child was sexually abused; if that location is one that the child had reportedly never been in, photographs should be taken to verify and corroborate the child’s information. In a case involving abuse by scalding, the investigator will want to obtain the hot water temperature in the child’s home.

Obtaining access to scenes and the preservation of evidence should be done by appropriate means and may necessitate such tools as search warrants.

**General Documentation**

The team should standardize the method of documenting all witness interviews in such a manner which permits flexibility for case circumstances and the possibility of court testimony. Disclosure in an abuse case often is a process in which information regarding abuse may be disclosed by the child over time. Examples of acceptable forms of documentation include written documents, audio tape or video tape (see below).
Interview of Child Victim/Witnesses

All interviews should abide by a Child First Doctrine. That is, the needs of the child are primary. Interviewers must use flexibility in responding to each individual child. A planned interview of a child witness/victim is generally preferred; however, the situation may require that the child be interviewed immediately. Considerations such as child safety, evidence preservation and immediate medical care may warrant an immediate interview.

Arrangements should be made to interview the child in an appropriate manner keeping in mind the goal to limit the trauma to the child as well as to provide for the child's safety and a thorough investigation. Prior to interviewing the child, the interviewer should be familiar with any information already obtained from other witnesses, including the circumstances of the initial disclosure.

The goal of the forensic interview of a child reporting sexual abuse is to gather as much reliable information as possible without re-victimizing the child in the process, regardless of whether it is conducted by a forensic interviewer, DCF/law enforcement IU or an individual investigator.

Collaborative/Joint Interviewing

Regional plans for forensic interviewing of children with reported sexual abuse should attempt to assure that interviews are coordinated and involve all agencies with investigative responsibility in each case. This should include:

- Avoidance of duplicative interviews by different interviewers.
- When more than one interviewer is present in the interview setting, one interviewer should be designated as the lead to avoid confusing the child.
- If more than one planned interview is necessary to obtain complete information, the initial interviewer should remain the same when feasible and appropriate.
- A process for information sharing among agencies should be agreed to by all agencies with investigative responsibility.
- Collaborative case planning should be developed.
- First Responders should be trained in minimal facts interviewing and attempt to gather pertinent information from sources other than the child. Training in minimal facts interviewing should be ongoing for appropriate agency staff, e.g. Police patrol, new DCF investigators and Treatment social workers.
Interviewers

Regional plans for the forensic interviewing of children reporting sexual abuse should attempt to insure that those who will be interviewing children:

1. Receive specialized training in forensic interviewing of children,
2. Communicate effectively with children,
3. Understand the dynamics of child sexual abuse,
4. Understand the developmental abilities of children at different ages,
5. Understand the needs of the legal system,
6. Commit to maintaining skills through continued training, review of relevant journals/research and attendance at peer review.

The Interview

1. The choice of the time for the interview should reflect the child's schedule and circumstances if at all possible.
2. Whenever possible, interviews should be conducted in the language with which the child is most comfortable.
3. Pre and post interview contact among relevant agencies should occur.
4. The interviewer should be provided with available background.
5. The interviewer should have access to the non-offending parent(s)/caretaker in order to gather information specific to the personality, language, developmental status, reactions/behaviors, and life situation of the child. The interviewer should have information regarding the reactions of the child's caretakers to the allegations of abuse.
6. Non-offending parent(s)/caretakers of the child should not be present in the interview setting with the child. If this cannot be avoided, instruct parents on his/her actions/behaviors while present.
7. Every effort should be made to consult with appropriate specialists regarding children with disabilities and include appropriate specialists in the interview (e.g. deaf interpreters) when appropriate.
8. Interviews should be conducted in a neutral, fact-finding manner.
9. MDTs should agree upon nationally accepted interviewing models to be used by all forensic interviewers for that MDT. All team members should be knowledgeable about the chosen model and should be capable of explaining and defending the model in court.

10. It must be recognized that in following a Child First Doctrine there will be times when a planned, forensic interview is not possible and someone other than the forensic interviewer will interview the child.

11. Anatomically detailed interview aides such as dolls and drawings should be used with caution according to recent research and practice. Anatomically detailed dolls should not be used unless the interviewer has received training in the use of such tools.

**Documentation of Interviews with Child Victims/Witnesses**

Multidisciplinary team protocols should include plans for documentation of interviews. Videotaping of interviews is recommended. However, documentation can be in the form of videotaping, audiotaping, or note taking. The goal is to accurately record the details of the interview. When the documentation is in writing only, the exact words of the child should be used whenever possible. Regardless of the form of the documentation, the format should be consistent whenever possible.

Multidisciplinary team protocols should address ownership, access and maintenance of the interview documentation, in particular video or audio tapes. Consideration should be given to requirements for maintenance of records as it affects different organizations. For example, if an interview is videotaped at a hospital, that record may be considered by the hospital as one of their medical records and the police would therefore obtain a copy with a certification rather than the original.

**Location, Equipment and Facilities**

The interview should take place ideally in a child appropriate and child friendly setting which may be developed in a variety of locations.

Interviewing a child in the vicinity of the reported abuse should be avoided.

The setting should be comfortable, informal, private, and free of distractions and disruptions. The setting should be one in which the child can feel physically and psychologically safe.
The Medical Evaluation

Specialized medical evaluation and treatment services should be available to all victims of physical/sexual abuse regardless of ability to pay. These services should be a component of a coordinated investigative response. Each region should develop a standardized process of coordination between law enforcement, child protection, investigative interviewer, and local hospitals/centers/medical providers.

The purposes of child physical and sexual abuse medical evaluations are to

1. obtain medical evaluation of the child, and treatment for the child when needed,
2. document and collect evidence of abuse, and
3. inform and reassure the child and family of the health status of the child.

Regional Responsibilities

Multidisciplinary teams should identify the geographically appropriate medical facilities or providers which can provide good quality medical evaluations for children, consistent with the recommendations of the Child Abuse Examination: State of Connecticut Supplemental Guidelines and other professional standards. Written agreements should be developed with those providers and/or with the institutions within which they function.

Criteria for referral should be developed to address:

1. scheduling of the medical evaluation
2. response in emergency situations (see below)
3. avoidance of multiple examinations
4. coordination of medical evaluations in order to avoid duplication of interviewing and history taking
5. availability of specialized examinations in the absence of a child abuse service in the region and
6. procedures for sharing the findings of the medical evaluation with investigators in a routine and timely manner.

The examination should be conducted by pediatric medical/nursing professionals experienced with techniques and procedures necessary to provide the appropriate medical and forensic evaluation. The medical facility or provider performing medical evaluations should be able to:

1. provide appropriate documentation of the examinations,
2. work collaboratively with the IU and the multidisciplinary team,
3. participate in judicial proceedings, and
4. participate in training and ongoing peer review.

The examination should be conducted in a setting appropriate for the developmental age
of the child or adolescent.

When a child’s medical condition requires urgent or emergency care, appropriate sources of medical care should be used immediately. Medical personnel should be informed of the need to document and assess for the potential of abuse. Upon stabilization of the medical condition, consultation with medical personnel with expertise in abuse should be sought by the team or IU.

Timing, location, documentation and preservation of evidence of child sexual abuse examinations is outlined in the Child Sexual Abuse Examination: State of Connecticut Supplemental Guidelines. In keeping with the intent of these guidelines:

- Efforts should be made to avoid examinations in hospital Emergency Departments except when essential to the collection of evidence and/or treatment of injuries or medical conditions.
- Efforts should be made to avoid all unnecessary examinations until a comprehensive child sexual abuse evaluation can be conducted.

The Evaluation

Most children and adolescents will require an examination to be reassured that they have not been physically damaged and remain in good physical health in spite of their victimization. Additionally, indications for a medical evaluation include:

1. history of actual or possible sexual contact in a child or adolescent in which there is a possibility of physical evidence or sexually transmitted infections, or medical complications, or
2. physical findings suspicious for abuse or neglect.

Medical evaluation should include:

1. history of the reported sexual contact or injury (the medical provider should not repeat the interview process already completed by the IU, but use their findings).
2. physical examination
3. collection of forensic material
4. medical management or any other appropriate medical services as indicated (e.g. laboratory testing)

Such services should be supported to assure (1) quality and reliable medical findings and (2) to assure each child has access to quality medical evaluation and management.

Members of agencies involved in investigating child sexual abuse should receive training regarding the purpose and nature of the medical evaluation and be able to educate clients and/or non-offending care givers regarding the medical evaluation. The goal of this training is to avoid unnecessary, inexperienced, and potentially traumatizing examinations of children.
Clinicians conducting specialized medical examinations are reimbursed for these specialized services.\textsuperscript{xviii}

\textbf{Mental Health Assessment}

Specialized mental health services for child victim and non-offending family members/caretakers should be available as part of the response to child abuse and neglect before, during and after the investigation.

The role and participation of mental health services should be written into team protocols developed to address child abuse and neglect. Team members with expertise in mental health should be expected to provide consultation to other agencies regarding mental health, developmental, emotional and therapeutic issues which impact child abuse and neglect cases/victims.

Mental health service providers are expected to share relevant information in case review while adhering to any confidentiality requirements.

The investigative interview should remain separate from mental health treatment. Consideration should be given to delaying the initiation of mental health treatment until the investigative interview process is complete. In some cases, however, the need for such therapeutic services will be immediate and necessary before the interview process can continue.

Planning should occur for the support of the child during future court proceedings.

\textbf{Victim Support}

Victim support should be made available throughout the investigation and prosecution. Whenever possible, victim support and advocacy should be available 24 hours a day, 7 days a week to victims and non-offending caretakers.

Support services in the area should be identified by each multidisciplinary team and participate as a member of each team. Access to support services should be included as part of all protocols developed.

General education for non-offending family members/caretakers regarding investigation, prosecution, and treatment should be routinely available throughout the investigation and prosecution. However, the specifics of any investigation or prosecution should not be shared if it would be detrimental to the investigation or prosecution of the case.

Designated, trained individuals should be available to provide victim support including, but not limited to
1. Crisis intervention following the assault or disclosure of abuse;
2. Client's rights;
3. Emergency Department support;
4. Court preparation;
5. Accompaniment to court or other locations;
6. Crime victim’s compensation information;
7. Assistance with access to services related to safety, finances, housing, transportation, etc.

Allegations Involving Multiple Children and Suspects

In situations where there is the potential for multiple child victims and/or perpetrators, such as a day care setting, pre-investigation planning is needed. Advance planning for such things as witness and interviewer separation and limited sharing of information should be decided upon ahead of time. The investigating agencies should decide how their efforts will be coordinated, the methods to be used in interviewing multiple children and the manner in which information will be shared among investigators or interviewers, if at all.

\footnote{Connecticut General Statutes (C.G.S.) Sec. 17a-106a(a) as amended by Public Act (P.A.) 98-241, Sec. 16 (hereinafter Sec. 17a-106a). This purpose is consistent with the statutory purpose of “multidisciplinary teams” as defined in Sec. 17a-106a(a).}

\footnote{See C.G.S. Secs. 17a-101h and 17a-106 regarding requirement of investigative cooperation between agencies.}

\footnote{C.G.S. Sec. 17a-106a(d).}

\footnote{C.G.S. Sec. 17a-106a(d).}

\footnote{C.G.S. Sec. 17a-106a(b).}

\footnote{C.G.S. Sec. 17a-106a(d).}

\footnote{See generally C.G.S. Secs. 17a-101h and 17a-106.}

\footnote{See C.G.S. Sec. 17a-106a(d).}
This will depend on what initial witnesses report and how the investigation develops.

C.G.S. sec. 46b-38a - d.

See C.G.S. Sec. 17a-101h regarding coordination of investigation activities and interviews with children. The consent of the non-offending parent may be required.

C.G.S. Sec. 17a-101h requires that child abuse investigators coordinate investigatory activities in order to minimize the number of interviews of any child and share information with other persons authorized to conduct child abuse or neglect investigations.

See for example American Professional Society on the Abuse of Children (APSAC) guidelines.

C.G.S. Sec. 17a-101f currently provides that expenses for examinations in suspected cases of child abuse and neglect, if not covered by insurance shall be paid by the Commissioner of the Department of Children and Families, though there is a question as to whether or not this only applies to 96 hour hold situations. C.G.S. Sec. 19a-112a(e) provides that the cost of collection of evidence shall be charged to the Division of Criminal Justice and may not be charged to the person being examined. C.G.S. Secs. 54-204 and 216 permit restitution to be made to victims of crime for medical services.

Applicable if the interviewer is someone other than those mentioned.

Sexual Abuse Medical Evaluation: Information for CT MDTs, Nina Livingston, MD, and CT Regional Sexual Abuse Examiners, 2007. Consult your MDT Coordinator for a copy.


See endnote xiv