CLARK COUNTY
STAFF REPORT

DEPARTMENT: Children's Justice Center (CJC)

DATE: May 17, 2016

REQUESTED ACTION:
The Clark County Councilors authorize and record the attached updated *Clark County Child Physical and Sexual Abuse Coordinated Response Protocol and Guidelines* as the official up-to-date written agreements developed by local professionals, and approved by the Children's Justice Center Executive Board, who defined the roles, protocol and collaborative coordination among responders who are responsible for addressing incidents of suspected child abuse in the Clark County area.

_X_ Consent ____ Hearing ___ County Manager

BACKGROUND
Written child abuse response professional agreements are required by Washington State to be developed and recorded locally pursuant to RCW 26.44.180. In addition, this protocol and guidelines should be kept regularly updated when changes in response systems occur.

COUNCIL POLICY IMPLICATIONS
No Council policy implications included.

ADMINISTRATIVE POLICY IMPLICATIONS
No administrative policy implications included.

COMMUNITY OUTREACH
The attached protocol includes necessary updates to reflect the current local child abuse coordinated response system of coordination among local professionals. The previous *Clark County Child Physical and Sexual Abuse Coordinated Response Protocol and Guidelines* was updated and approved in 2010.

BUDGET IMPLICATIONS

N/A - BUDGETARY IMPLICATIONS ARE NOT APLICABLE

BUDGET DETAILS
N/A - NO BUDGET DETAILS APPLICABLE

DISTRIBUTION:
Board staff will post all staff reports to The Grid. http://www.clark.wa.gov/thegrid/

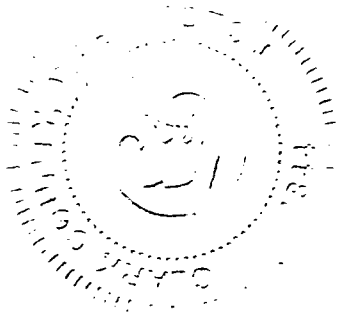
Mary Blanchette, CJC Executive Director

DATE: 5/3/16

APPROVED:
CLARK COUNTY, WASHINGTON
BOARD OF COUNTY COUNCILORS

DATE: May 17, 2016

SR# SR 104-16



APPROVED:
Mark McCauley, County Manager

DATE: _____

CLARK COUNTY
CHILD PHYSICAL AND SEXUAL ABUSE
COORDINATED RESPONSE
PROTOCOL & GUIDELINES

(*MARCH 2016*)

Introduction

These guidelines and protocols have been developed by a "Child Abuse Response Protocol Committee" convened and distributed by the *Arthur D. Curtis Children's Justice Center* to assist professionals and agencies involved in response to suspected incidents of child abuse in effective coordination and communication.

The *Clark County Physical and Sexual Abuse Response Protocol and Guidelines* were established with the following goals:

- Provide a clear framework for a fully coordinated and multidisciplinary response to incidents of child abuse
- Ensure optimum communication and collaboration among responders, while maintaining role distinctions
- Encourage understanding and respect for the different goals and responsibilities of participants, and avoid conflicts that may interfere with the efficiency, timeliness, and reliability of the investigation
- Increase the overall reliability of the investigation
- Increase requisite skills through specialized training, coordination, and critical review of actions taken
- Protect the important interests of children and suspects
- Minimize the number of interviews of reported victims

In no case are these guidelines and protocols intended as legal authority for the admissibility or non-admissibility of evidence developed in the course of an investigation. Similarly, these guidelines should not be used as the basis for the dismissal for any charges or complaints arising from a report of child abuse.

CLARK COUNTY CHILD ABUSE RESPONSE PROTOCOL & GUIDELINES

I. PURPOSE

This protocol purpose is to provide written guidelines for all responders across Clark County regarding criminal child abuse response coordination pursuant to RCW 26.44.180.

II. AGENCY ROLES & RESPONSIBILITIES (Alpha Order)

1. **Advocates**
   Victim Advocates provide advocacy services for victims of child sexual and physical abuse. Advocacy services include support to victims and their nonoffending family members during law enforcement investigations, during prosecution phases including defense attorney interviews, trials and court hearings. Medical advocacy may be provided by advocates for victims who need medical examination related to a possible child abuse crime.

2. **Attorney General**
   The Attorney General's Office shall provide legal advice and representation for Child Protective Services.

3. **Child Abuse Assessment Team (CAAT)**
   A Legacy Salmon Creek Medical Center clinic that provides medical evaluation and treatment for child physical abuse, sexual abuse and neglect. This evaluation is provided by a qualified Child Abuse Medical Provider for children in southwest Washington where there is a suspicion of child abuse and a need for health care with this medical specialization.

4. **Child Abuse Medical Provider**
   A medical provider with specialized and up to date training in the evaluation and treatment for child victims of sexual abuse, physical abuse and neglect. The primary role of this provider is to assist with medical triage and comprehensive evaluation of child victims for injuries and/or potentially sexually transmitted infections. This provider will consult as needed with community partners involved in the investigation.

5. **Child Protective Services**
   Child Protective Services (CPS) will have the responsibility to investigate allegations of abuse and neglect, to assess safety and risk to children, to develop and/or monitor a safety plan when appropriate, to facilitate placement when necessary to ensure the safety of the child(ren), and refer families to services that address risk to children. Child Protective Services will respond to intakes in accordance to Statute and Division of Children and Families Services' policy.

6. **Clark Regional Emergency Services Agency (CRESA) 911 Dispatchers Center**
   Clark Regional Emergency Services Agency (CRESA), which is the sole 9-1-1 answering point for Clark County. CRESA has specific written directives that guide 9-1-1 dispatchers in sending appropriate public safety response on child abuse, sex crimes, domestic violence, assaults, child fatalities and abductions.

7. Community Based Advocacy Services
   Local 501c3 nonprofit agencies providing advocacy, education and support services for victims, not legal advocacy for child victims involved in criminal child abuse case.

8. **Emergency Medical Services (EMS) and Fire District Personnel**
   EMS is responsible for responding to requests for medical help of victims of abuse and neglect, with the primary role to preserve life, treating illness and injury, transporting to appropriate medical care facilities and maintaining a potential crime scene for investigation. In addition, EMS personnel will provide necessary information to receiving health care providers, law enforcement, and the Medical Examiner in cases of suspected abuse and neglect.

9. **Juvenile Probation Counselor**
   Supervises juveniles who have been placed on probation by the Juvenile Justice system, which includes monitoring activities, linkages to supportive services and evaluating the juvenile's progress.

10. **Law Enforcement**
    Primary responsibility for the criminal investigation of reported child abuse allegations shall be with law enforcement.

11. **Law Enforcement and CPS Investigative Roles Defined**:
    a. Though the responsibility for the criminal investigations of child abuse rests with law enforcement, joint interviews with CPS may take place when such resources are available, and when the allegations meet the criteria for CPS involvement.

    b. Persons necessary to the investigation may observe interviews, with the goal of minimizing the trauma to the child, and limiting the number of interviews.

    c. Law enforcement will be responsible for documenting and being the primary custodian of the record of the interview.

    d. Both CPS and law enforcement should cooperatively determine when a case requires joint investigation.

    e. Should disputes arise amongst the agencies during the investigation, representatives from each agency will meet to discuss resolution. However, such a delay should not affect the safety of the reported victim and not jeopardize the integrity and timeliness of the ongoing investigation.

12. **Medical Examiner**
The primary role of the medical examiner is to investigate the deaths of individuals over which the medical examiner has jurisdiction; the purpose of the investigation is to determine the cause of death. The types of deaths for which the medical examiner assumes jurisdiction include those resulting from: homicide, accident, suicide, deaths from unknown or obscure causes, deaths while in jail or prison, deaths under suspicious or unusual circumstances, deaths constituting a threat to the public health.

13. **Medical Providers, including Emergency Rooms and Hospitals**
Medical providers working within emergency rooms and hospitals primary roles are to preserve life, treat illnesses and injuries. However, as mandated reporters they are also required by law to report any suspected incidents of child abuse that they may encounter during the course of their work in a timely manner, and to provide any health information related to child abuse to investigators and the Medical Examiner to assist them in their role.

14. **Mental Health Providers**
Due to the trauma commonly caused by child abuse, responders recognize the importance of referral and linkages to mental health service to give victims and non-offending family members the opportunity to access mental health services and treatment necessary to heal and recover from the psychological ramifications caused by child abuse.

15. **Prosecuting Attorney**
The Clark County Prosecuting Attorney's Office (PAO) is the agency charged with the prosecution of all felonies committed in Clark County and those misdemeanors not committed within municipal jurisdictions. The PAO reviews investigative materials from law enforcement agencies, makes charging decisions, and prosecutes cases as appropriate. The PAO is available to consult with law enforcement agencies about child abuse investigations.

III. SUSPECT AND WITNESS INTERVIEWS

A. Requirements:

1. Law enforcement shall make reasonable attempts to interview all alleged offenders.

2. Interviewers will make reasonable efforts to interview the identified person(s) who were involved in the initial disclosure of, or witnessed an incident, of child sexual or physical abuse.

3. In cases where CPS is involved and required to interview a parent or guardian who has been identified as the suspect, all reasonable attempts shall be made to provide for coordination of this interview between CPS and law enforcement. Wherever possible, CPS will attempt to accommodate the requests of law enforcement with respect to timing of such interviews.

4. Law enforcement should make reasonable attempts to utilize appropriate investigative tools (i.e. search warrants, processing of a crime scene, interviews of

corroborative and or alibi witnesses) when applicable.

IV. CHILD INTERVIEWS

The primary purpose of the interview of child is to seek the truth regarding the allegations that have been made.

A. Interviews:

1. The child interview shall be conducted in a nonjudgmental and unbiased manner that invites narrative recall.

2. The interviewers will attempt to discern the child's developmental level and utilize the appropriate language.

3. The interviewer shall attempt to discern the level of communication proficiency of the child and utilize an interpreter when needed.

4. The interviewers, of children under the age of 10, or older children with obvious and significant developmental delays should comply with the RCW 43.101.224 and RCW 74.14B.010, unless circumstances require immediate action.

5. Reasonable efforts will be made to interview children in a neutral setting in order to minimize any discomfort to the child.

6. Victim interviews will be recorded (audio or visual) whenever possible and otherwise comply with RCW 26.44.035 when applicable.

7. Responders will consider the involvement of a support person of the victim's choice to be present in a child interview, when appropriate, and if the presence of a support person does not jeopardize the course of an investigation pursuant to RCW 70.125.060 and RCW 26.44.030(14)(a)(i).

V. MEDICAL EVALUATION, EVIDENCE AND TREATMENT

A. Requirements

1. A medical examination performed by a qualified medical professional may provide relevant and reliable information and child treatment regarding sexual or physical abuse of a minor. The multi-disciplinary team recognizes qualified medical providers based upon specialized training in conducting comprehensive evaluations of children, access to specialized equipment and experience with medical child abuse evaluation.

2. Emergency Medical Services (EMS) and emergency room/hospital staff will perform an evaluation of the minor per their standard treatment protocol, focusing on the patient's immediate medical stabilization. Once the minor is felt to be medically stable, EMS/Hospital staff will assure CPS contact and a nurse with specific Sexual Assault Nurse Examination (SANE) training may perform a sexual assault examination for specimen collection in children 15 years or older. ED providers will perform the

exam for younger victims.

The hospital staff will assist with referral to medical provider with specialized training in pediatric sexual assault, physical assault and neglect examinations and encourage parents to consult with the qualified provider regarding the need for further physical examination of the child.

3. The hospital staff will assist with referral to medical provider with specialized training in pediatric sexual assault examinations and encourage parents to consult with the qualified provider regarding the need for further physical examination of the child. Medical referrals for suspected child sexual abuse, physical abuse or neglect should be sent to Legacy Salmon Creek Child Abuse Assessment Team (CAAT).

4. All parents should be encouraged as soon as possible to consult with an identified, qualified provider regarding the need for a physical examination of the child.

VI. MULTIDISCIPLINARY TEAM CASE REVIEW

A. The Arthur D. Curtis Children's Justice Center (CJC) is Clark County's Children's Advocacy Center and is accredited by the National Children's Alliance. CJC holds regular multidisciplinary case reviews for criminal child abuse cases to increase understanding of the facts and increase the coordinated response among safety, justice, and healing professionals.

B. A multidisciplinary case review should include, but is not limited to, representatives from the following disciplines who can represent the disciplines below or are professionals involved in the case and may have relevant information:
   - Law Enforcement
   - Prosecuting Attorney
   - Child Protective Services (CPS)
   - Assistant Attorney General
   - Victim advocate
   - Medical professional
   - Mental Health provider
   - Civilian Forensic Interviewer
   - Juvenile Probation Officer

C. A designated facilitator for the formal monthly Multidisciplinary (MDT) case review meetings held at the Children's Justice Center (CJC) should be facilitated by a discipline-non-case carrying neutral professional who is not present to represent one of the six core case review disciplines (i.e., law enforcement, prosecution, CPS, mental health, medical and victim advocacy), in accordance with the accrediting standards set by the *National Children's Alliance* to, "... ensure that no one discipline has the opportunity to dominate the MDT case review discussions."

D. In the best interests of the child other mandated reporters pursuant to RCW 26.44.030 may be invited to join the case review core group to enhance comprehensiveness of the case review.

E. Persons or agencies exchanging information at the case review shall not further disseminate or release the information except as authorized by state of federal statute.

VII. SERIOUS PHYSICAL ABUSE INCLUDING CHILD FATALITY

This section pertains to serious physical abuse, referring to the non-sexual non-accidental injury of a living child as defined in RCW 9A.04.110(4), (26), and (27), and RCW 26.44.020(1), as well as the death of a child occurring as a result of non-accidental injury or under suspicious circumstances.

A. Fully Coordinated Response

System personnel each have detailed protocols and procedures that specify the steps to be included in the investigation and/or documentation of child physical abuse. This guideline addresses the coordination of these processes at the earliest possible point.

1. LAW ENFORCEMENT RESPONSE:

Law Enforcement Response for Physical Abuse

a) Respond to child abuse referral or 911 call-outs
b) CJC or Jurisdictional Representatives will coordinate further response with Major Crimes Units or the Regional Major Crime Unit if applicable.
c) Notify CPS. Share available information with CPS when appropriate.
d) Conduct an investigation, including determining timing and order of interviews. Invite coordination with CPS as appropriate where parallel investigations overlap. Effect forensic interviews as necessary.
e) If child is hospitalized and will be released from the hospital, consult with CPS regarding need for placement if appropriate.
f) Consult with hospital Social Worker for additional information.
g) Consider safety of children and consult with CPS regarding possible placement.
h) Request medical consultation and/or examination with a child abuse physician consultant for clarification of medical issues as needed.
i) Make referral to Legacy Salmon Creek Medical Center Child Abuse Assessment Team (CAAT) clinic

Law Enforcement Response for Child Fatality

a) Respond to referrals or call outs
b) Report death to the Medical Examiner Office.
c) CJC or Jurisdictional Representatives will coordinate further response with Major Crimes Units or the Regional Major Crime Unit.
d) Notify CPS. Share available information with CPS when appropriate.
e) Consider removal of other children in the home who may be at risk, in consultation with CPS.
f) Coordinate scene investigation and complete the SUIDI form (see attached) with Medical Examiner Investigator.

2. CPS RESPONSE:
   a) Begin investigation once intake has been screened in.
   b) Refer to law enforcement immediately, within 24 hours of receipt when possible.

c) Contact law enforcement supervisor to ensure receipt and assigned investigator.
d) Share appropriate information with law enforcement investigator and coordinate investigative response to the extent possible while remaining in compliance with independent objectives, statutes, regulations and agency policies.
e) Employ appropriate safety framework to assess the safety of the children in the home, develop an in-home safety plan when appropriate, and seek law enforcement or court intervention if out of home placement is deemed necessary.
f) Defer to law enforcement regarding investigation with regard to timing of interviews while remaining in compliance with statute, regulation and agency policies in regard to response times.
g) Arrange medical consultation with child abuse physician consultant for clarification of medical issues

3. EMERGENCY MEDICAL SERVICES OR FIRE DEPARTMENT RESPONSE
a) EMS will respond to calls for serious physical abuse and child death as per Clark County Operating Procedures for EMS response
b) EMS has a primary role to preserve life but will disturb the crime scene as little as possible.
c) Victims will be treated and transported as per Clark County Protocols for EMS Providers
d) Scene will be maintained and secured and will utilized one path in and out of the potential crime scene.
e) Law enforcement will immediately be notified through CRESA
f) Leave the area as is prior to Law Enforcement investigation, do not clean, do not flush the toilet, and do not remove garbage or trash.
g) EMS will wait until Law Enforcement arrives to report observations before leaving the scene.
h) All necessary information including initial dispatch, scene findings, medical/incident history, provided, and patient response to treatment will be given to the receiving physician
i) In cases where the patient is not transported and determined dead in the field, EMS providers will follow Clark County protocol for notification of Law Enforcement and the Medical Examiner
j) Leave the victim where EMS found them if there is a fatality; do not remove a dead body
k) Keep all family members and personnel out of scene area once the fatality has been determined.
l) Document any statements made and the setting of the area.
m) Notify Medical Examiner if there is a fatality
n) Notify Trauma Intervention Program

4. MEDICAL EXAMINER RESPONSE:
a) Upon notification of a death, Medical Examiner Investigators will obtain and review available information, and consult with the Medical Examiner if necessary, to determine whether to assume jurisdiction over the death.
b) The medical examiner staff will coordinate with the law enforcement agency having jurisdiction the investigation of the scene and the circumstances surrounding the death.

c) Medical Examiner Investigators (ME Investigators) will respond to the location of death, conduct a scene investigation, and transport the decedent to the ME facility.
d) Medical examiner personnel will notify the appropriate law enforcement agency of information identified during the investigation that would warrant further investigation by law enforcement as soon as practicable.
e) An opinion by the Medical Examiner concerning the cause and manner of death may require further studies and/or investigation by both law enforcement and medical examiner staff. This may result in a case remaining in a pending status for an extended period of time.
f) Medical examiner may consult with the designated Child Abuse Medical Provider in Clark County.

5. HOSPITAL RESPONSE:
a) Hospital notifies both law enforcement and CPS immediately.
b) In case of the need to transfer the child to another medical center/hospital, the transferring facility will notify both law enforcement and CPS immediately, as well as notify the accepting facility to assure law enforcement and CPS involvement.
c) Hospital may contact child abuse medical physician for consultation.
d) Hospital staff avoids extensive interviews with parents or children regarding the cause of the injuries once concern of child abuse rises to level of suspicion that would lead to a CPS report. Following medically necessary interviews, hospital staff defer to law enforcement and CPS regarding investigative steps and placement decision-making

VIII. SEXUAL ABUSE

This section refers to any sexual assault or sexual abuse of a minor including conduct defined in RCW 26.44.020(22) (b) and prohibited in RCW chapter 9A.44 and RCW 9.68A.040 and .090..

A. Fully Coordinated Response

System personnel each have detailed protocols and procedures that specify the steps to be included in the investigation and/or documentation of child physical abuse. This guideline addresses the coordination of these processes at the earliest possible point.

1. LAW ENFORCEMENT RESPONSE:
a) Respond to child abuse referrals and 911 call outs.
b) CJC or Jurisdictional Representatives will coordinate further response, and contact Major Crimes Units or the Regional Major Crime if applicable.
c) Notify CPS. Share available information with CPS, when appropriate.
d) Conduct an investigation, including determining timing and order of interviews. Invite coordination with CPS as appropriate where parallel investigations overlap. Effect forensic interviews as necessary.
e) If child is hospitalized and will be released from the hospital, consult with CPS regarding need for placement if appropriate.
f) Consult with hospital Social Worker for additional information.
g) Consider safety of children and consult with CPS regarding possible placement.
h) Make medical referral to Legacy Salmon Creek Medical Center's Child Abuse Assessment Team Clinic (CAAT).

2. CPS RESPONSE:
   a) Begin investigation once intake has been screened in.
   b) Refer to law enforcement immediately, within 24 hours of receipt if possible.
   c) Contact law enforcement supervisor to ensure receipt and assigned investigator.
   d) Share appropriate information with law enforcement investigator and coordinate investigative response to the extent possible while remaining in compliance with independent objectives, statutes, regulations, and agency policies.
   e) Employ appropriate safety frameworks to assess safety of the children in the home, develop a safety plan when appropriate, and seek law enforcement or court intervention if out of home placement is deemed necessary.
   f) Defer to law enforcement regarding investigation with regard to timing of interviews while remaining in compliance with statute, regulation and agency policies in regard to response times.
   g) Arrange medical consultation with child abuse physician consultant for clarification of medical issues.

3. Provide services to victim and/or family members to include the following:
   a) Process for obtaining a protection order
   b) Medical advocacy
   c) Emotional support
   d) Resource referrals
   e) Legal advocacy (i.e., present during the Prosecution phase and defense interviews and legal hearings and trial)
   f) Life skills support

4. HOSPITAL RESPONSE:
   a) Hospital notifies both law enforcement and CPS immediately.
   b) In case of the need to transfer the child to another medical center/hospital, the transferring facility will notify both law enforcement and CPS immediately, as well as notify the accepting facility to assure law enforcement and CPS involvement.
   c) Hospital may contact child abuse medical physician for consultation.
   d) Hospital staff avoids extensive interviews with parents or children regarding the cause of the injuries once concern of child abuse rises to level of suspicion that would lead to a CPS report. Following medically necessary interviews, hospital staff defer to law enforcement and CPS regarding investigative steps and placement decision-making
   e) Sexual Assault Nurse Examiners (SANE) or MD/DO will assess the child for physical injuries, perform specimen collection and take photographs as indicated per protocol. The SANE nurse will involve the Emergency Department Physician as necessary or if the victim is less than 15 years old.

5. EMERGENCY MEDICAL SERVICES AND FIRE DEPARTMENT RESPONSE
   a) EMS will respond to calls for child sexual abuse as per Clark County Operating Procedures for EMS response
   b) EMS has a primary role to preserve life but will disturb the crime scene as little as possible.
   c) Victims will be treated and transported as per Clark County Protocols for EMS Providers

d) Scene will be maintained, secured and will utilized one path in and out of the potential crime scene.
e) Law enforcement will immediately be notified through CRESA
f) Leave the area "as is" prior to Law Enforcement investigation, do not clean, do not flush the toilet, do not remove garbage or trash.
g) EMS will wait until Law Enforcement arrives to report observations before leaving the scene.
h) All necessary information including initial dispatch, scene findings, medical/incident history, treatment provided, and patient response to treatment will be given to the receiving physician
i) In cases where the patient is not transported, EMS providers will follow Clark County protocol for notification of Law Enforcement.
j) Leave all items where EMS providers found them if there is a fatality
k) Keep all family members and personnel out of scene area once the fatality has been determined.
l) Document any statements made and the setting of the area.
m) Notify Trauma Intervention Program

VIII. Responding to Minor Sex Trafficking Cases:

Minor sex trafficking is defined as a commercial sexual exploitation of a person under 18 years of age for economic gain including conduct defined in RCW 26.44.020(22)(a) and prohibited in RCW 9.68A.100, .101, .102, or .103. All aspects of the response outlined in section IX *Sexual Abuse* in this protocol are relevant to minor sex trafficking cases. In addition, the following elements are added to provide criteria that increases the coordinated response in the event that a minor discloses that he or she has been trafficked or where sufficient evidence exists to suspect that a minor has been sex trafficked.

A. LAW ENFORCEMENT RESPONSE
1. LE will coordinate with CJC to ensure that the victim is linked to a comprehensive child abuse response system. CJC may or may not assume an investigative role on a minor sex trafficking case, depending on the level of complexity and particular needs of the victim.
2. Forensic interviews of the victim may be held at CJC when appropriate.
3. Consults with CPS regarding placement of the victim if appropriate.
4. LE will ensure the victim is referred to a sexual assault advocate to promote the provision of supportive services at the onset of the case.
5. To assure the physical wellbeing of the child, as well as the preservation of evidence, LE will refer victims for urgent medical care within 72 hrs. of any suspected incident of sexual abuse. Referral for a follow up examination by a specially trained medical provider with expertise in child abuse evaluation may also be needed

B. CPS RESPONSE:
1. Begin investigation once intake has been screened in.
2. Refer to law enforcement immediately, within 24 hours of receipt if possible.
3. Contact law enforcement supervisor to ensure receipt and assigned investigator.
4. Share appropriate information with law enforcement investigator and coordinate investigative response to the extent possible while remaining in compliance with independent objectives, statutes, regulations, and agency policies.

5. Assess safety of the children in the home and develop a safety plan when appropriate, or seek law enforcement or court intervention if out of home placement is deemed necessary.
6. Defer to law enforcement regarding investigation with regard to timing of interviews while remaining in compliance with statute, regulations and agency policies in regard to response times.
7. Arrange medical consultation with child abuse physician consultant for clarification of medical issues

C. COMMUNITY-BASED ADVOCACY SERVICES:
1. Responds to requests from Juvenile Justice staff for advocacy services for youth with significant risk factors for sex trafficking, but where no disclosure has been made.
2. Report to L.E. or CPS regarding a minor's disclosure of sex trafficking or where sufficient information lends to a suspicion of minor sex trafficking.

D. JUVENILE COURT
1. Detention and probation staff will assess all youth for risk factors related to sex trafficking.
2. Report to L.E. or CPS regarding a minor's disclosure of sex trafficking or where sufficient information lends to a suspicion of minor sex trafficking.
3. Contact the YWCA Sexual Assault Program for advocacy services for youth "at-risk" of having been sex trafficked.
4. Detention and probation staff will contact CPS regarding an appropriate placement for an identified sex trafficked youth, including a family search if necessary.
5. Detention and probation staff will access appropriate medical care for a youth who has been sex trafficked, which includes the utilization of medical providers skilled in evaluation and treatment of minor sexual assault victims.
6. 4) Probation Counselors will coordinate with other responders to ensure a multidisciplinary response for minor sex trafficking victims. In cases where there are challenges to providing an appropriate response of community services, the CJC multidisciplinary monthly case review meeting will be utilized to create a comprehensive response for minor sex trafficked victims involved with the juvenile justice.

IX. EFFORTS TO PRESERVE THE CRIME SCENE

A. Maintenance of the Crime Scene
1. Disturb the possible crime scene as little as possible while preserving life

2. Identify one clear path for entrance and exit into the crime scene

3. Wear protective clothing to shield both scene and responder

4. Preserve information until law enforcement arrives including, but not limited to the following:
   a) not removing a clearly dead body
   b) leaving the area as is; do not clean or remove garbage or trash
   c) not flushing the toilet

d) preventing others from entering the crime scene or removing or disturbing anything from the crime scene

1. Observe and identify potential witnesses and document any statements made

2. Wait until law enforcement arrives to report observations before leaving the scene

X. INFORMATION SHARING

A. Requirements:

1. When necessary to further the investigation and ensure the safety of the child, information shall be shared as soon as possible, among the appropriate multi-disciplinary team members.

2. Information sharing should ensure confidentiality, integrity of the criminal investigation, protection of the child and protection of individual rights pursuant to statute.

XI. METHODS OF PROTECTING CHILDREN DURING INVESTIGATION:

A. Requirements:

1. Law Enforcement and Child Protective Services will consult when appropriate regarding decisions as to the placement of the child, removal of the suspect/subject from the home, or other plans to protect the child. .

These decisions should take into consideration the protection of the child from retaliation, or efforts to influence statements or the testimony of the child.

2. When making decisions regarding placement of a child in protective custody and ongoing placement, law enforcement and Child Protective Services will share all information relevant to the placement decision, while complying with the statutory obligations.

3. Attempts shall be made to minimize the number of interviews of the child to prevent unnecessary trauma to the child.

4. When possible and appropriate, child and adolescent victims of sexual or traumatic physical injury should be referred to/made aware of available mental health services in order to assist them in processing their experience and promote recovery.

XII. TRAINING AND QUALIFICATIONS OF INTERVIEWERS:

A. Requirements:

1. In order to ensure that all persons who have primary responsibilities for interviewing abused children are provided with training as specified in RCW

74.14B.010 Each agency shall be responsible for making training arrangements for their staff and providing funding for attendance of necessary Training.

XIII. CASE CLOSURE

A. Requirements:

1. Closing a Case:

   a) Law Enforcement Case: Upon completion of a criminal investigation by Law Enforcement and a review of the case by the Prosecuting Attorney's Office, it shall be appropriate to close the case when; a) no criminal action will be pursued or, b) the case has progressed through the criminal justice system to resolution or, c) suspended pending further development

   b) Child Protective Services Case: It shall be appropriate to close a CPS Investigation when the investigation is complete, a determination of a "finding" as to the allegation(s) has been made and an assessment of risk has been completed. The case may be closed if it has been determined that there is no substantial risk of harm to the child. In other situations, the case will be transferred to an ongoing social worker who will continue to monitor the safety of the child and provide services to the family (when appropriate), either with Dependency Court involvement or voluntary services.

   c) Medical Examiner Case: Upon completion of the death investigation by the Office of the Medical Examiner, a copy of the confidential autopsy and toxicology report will be forwarded to the law enforcement agency responsible for the law enforcement investigation. The appropriate law enforcement agency representative and/or prosecuting attorney will be contacted, prior to the release of autopsy and toxicology reports requested by family members for deaths involving suspected abuse.

2. Notice of a Case Closure

   a) After receiving a report of child abuse from law enforcement as described in RCW 26.44.030(5), the PAO shall notify the victim, any persons the victim requests, and CPS of the decision to charge or decline to charge a crime, within five days of making the decision. RCW 26.44.030(6).

   b) At the closure of the CPS investigation, the subjects of the investigation receive written notification of the "findings" with respect to the allegations in the initial referral. As stated above, completion of the investigation may result in the case being transferred to an ongoing social worker for either voluntary services or because Dependency Court is involved.

ADDENDUM 1: RESPONDERS GUIDELINE REFERENCE

C-POD Guidelines for First Responders: Child Deaths & Serious Physical Injury Cases

These are only guidelines.
Not all information may be pertinent or available. Follow local procedures & established protocols!

These guidelines provide a quick review of recommended approaches in cases where a child has died suddenly & unexpectedly, or sustained serious unexplained or suspicious physical injury. They list important considerations for 1st responders (especially CPS/DLR, Law Enforcement, and EMS/paramedics) during an immediate response to the scene where the child was injured or found. Determination of the cause of death or mechanism of injury will depend on the results of a complete investigation & medical evaluation. In addition to considering these suggestions, please note any other relevant information. *Keep in mind*: not all items apply in all cases – each situation is different & the appropriate response will vary depending upon available resources & the specific facts of the case.

Produced in 2006 by the WA State Criminal Justice Training Commission (CJTC) & funded by a DSHS Children's Justice Act grant, the C-POD Guidelines are based on a series of meetings held throughout WA State, facilitated by Patti Toth & Ilana Guttmann, who also compiled the guidelines.

For additional resources & training information, go to the CJTC website at www.cjtc.state.wa.us or contact CJTC Program Manager Patti Toth at ptoth@cjtc.state.wa.us.

Beyond the C-POD Guidelines: Improving Community Response to Child Fatalities and Serious Physical Abuse Cases

1. Revise & expand scope of your *county* ***Child Sexual Abuse Investigation Protocol*** to address child fatalities & serious physical abuse cases; involve additional local professionals & agencies:
   - *EMS & Fire District personnel*
   - *Coroner or Medical Examiner*
   - *Medical providers: ER/Hospitals*
   - *Comm. Center/ 911 dispatchers*
2. Utilize a *multidisciplinary approach* to these investigations
3. Use the ***SUIDI form*** *(Sudden Unexplained Infant Death Investigation)* for infant deaths
4. Develop your own *checklists*: include pertinent local phone #s
5. Participate in local ***child death review*** teams to plan follow-up investigations and de-brief

COLLABORATION

*Ensure an **immediate, coordinated investigation** of **ALL** unexpected child deaths & serious injuries.*

✓ Immediately summon **EMS**

✓ Immediately call **Law Enforcement** to scene of injury or death *(and to hospital if child has been transported)*

✓ Immediately call **CPS** to scene(s):
Central Intake: ***800-562-5624***
(Law Enforcement: press "9")

✓ Contact/notify other key players ASAP *as appropriate:*

- ❑ Special Unit Detective(s)
- ❑ Medical Examiner/Coroner
- ❑ Dept. of Licensed Resources (DLR): *if licensed/unlicensed daycare, etc.*
- ❑ **MedCon** *(free expert medical consultation):* **800-326-5300**
- ❑ WSP CSRT, Crime Lab (total station)
- ❑ Prosecutor; other involved agencies
- ❑ Tribal Authorities
- ❑ Language Interpreter
- ❑ Counselor/ Clergy/ Chaplain
- ❑ Animal Control, Bldg. Inspector, etc.

✓ **Consider:**

- ❑ Who may/may not have been alerted
- ❑ People necessary to ensure full investigation
- ❑ Cause of injury/death is often not immediately obvious

✓ **Exchange information:**

- ❑ Observations of all 1st responders
- ❑ Contact information for all responders
- ❑ History of child, family, caregivers, residence, etc. (Any patterns?)

✓ **Clarify roles:**

- ❑ Who needs what info, when & how?
- ❑ Who has the expertise/training to…
  - Manage the scene (lead)
  - Gather/document information
  - Interview witnesses (incl. children)
  - Preserve evidence
  - Assess ongoing safety of child(ren) in home
  - Determine need for protective custody of child(ren), identify appropriate placement

PRESERVATION

Maintain scene as it was when child (or injury) was discovered until evidence is seized, is documented, and/or circumstances are demonstrated or reconstructed.

- ✓ Strive first to preserve life: Render all necessary medical aid
- ✓ Disturb scene as little as possible
- ✓ Prevent others from disturbing evidence
- ✓ Secure the scene - Keep everyone at scene(s) until all info. gathered
- ✓ Clearly identify how 1st responders enter/exit the scene *(limit contamination)*
- ✓ Wear protective clothing to shield both scene and responder
- ✓ Preserve information: Interview witnesses *(on video)*; take photos *(at scene of injury & at ER/hospital if child there);* and record detailed observations ASAP

- ✓ Disturb scene as little as possible:
  - ☒ **Don't** move a clearly dead child
  - ☒ Don't turn on/off appliances
  - ☒ Don't allow garbage to be emptied
  - ☒ Don't change clothes/diapers - if you do, keep the clothing/diaper
- ✓ Prevent anyone from destroying potential evidence:
  - ☒ Don't use or flush toilet or sink
  - ☒ Don't unnecessarily step on/into sensitive areas
  - ☒ Don't mop up fluids or clean anything (bedding, dishes, etc.)
  - ☒ Don't throw anything away at or from the scene
- ✓ Preserve all evidence at the scene(s):
  - ❑ Consider multiple scenes: Where injury occurred, vehicle, ER, etc.
  - ❑ Control/ minimize access to scene
  - ❑ ID witnesses - **conduct thorough witness interviews ASAP**
  - ❑ Take lots of photos/videos
  - ❑ Removal of anything requires lawful authority (search warrant, written consent, etc.)

OBSERVATION

Be aware and conscious of everything within the environment.
Use all your senses.
***Suspend assumptions** in order to absorb maximum amount of info.*

- ✓ The child's location, position, observable injuries, physical state (e.g., skin temp./color, lividity, etc.)
- ✓ All people at the scene(s)
- ✓ Demeanor of witnesses
- ✓ Outdoor and indoor environment
- ✓ Caretaker explanation(s):
  - ❑ *Consistent with injuries and/or observations?*
  - ❑ *Contradictory statements to different people?*
- ✓ Objects at scene(s) - possibly involved in mechanism of injury
- ✓ What's moved/changed? What's odd? What's missing?
- ✓ Cultural, religious and/or ethnic factors - remedies, language, etc.
- ✓ Who rendered what aid?
- ✓ Who is present/not? **Other children**?
  - ❑ Where and with whom are they? Physical & emotional state(s)?
  - ❑ Demeanor, utterances, actions
  - ❑ Requests (e.g., lawyer, translator, clergy, etc.)
  - ❑ Impairments (visual, motor, auditory, etc.)
- ✓ Outdoor & indoor environment:
  - ❑ Configuration, order/disorder, cleanliness, noise
  - ❑ Sleeping environment
  - ❑ Ventilation; are windows & doors open or closed? (Un)locked?
  - ❑ Temperatures and hazards: Water, toxins, weather, etc.
  - ❑ Fluids/ odors/ discolorations
  - ❑ Pets/animals & their condition(s)
  - ✓ Presence/lack/condition of/info from:
    - ❑ Bedding, food, drugs, meds, etc.
    - ❑ Appliances? On or off?
    - ❑ Computer screen, cell & other phones, answering machines
    - ❑ Vehicles - Note if/when (re)moved

DOCUMENTATION

Immediately record everything about the scene, the child, and witnesses.

- ✓ Who first noted distress/injury- when, where, what - their actions?
- ✓ When & who called for assistance? Any delay? Who else was called?
- ✓ Identity & contact info. for all key players – present at scene or not
- ✓ Observations of/about everyone on scene and/or with child
- ✓ Everything said (including excited utterances): How, when, by whom?
- ✓ Create timeline before & after injury: *48 to 72 hours* (use a calendar)
  - All who had contact with child
  - Location(s) of child
  - Events, behaviors, activities, medical issues (& changes in these)
  - Food & medications ingested
  - Sleep and awake time
- ✓ Full description/depiction of scene
- ✓ Caretakers' attitudes re: child

- ✓ Name, DOB, phone, current and prior names & addresses for:
- ❑ Children at scene, in family/facility
- ❑ Legal custodians/ all caretakers
- ❑ Primary & collateral witnesses: family, neighbors, teachers, etc.
- ❑ 1st responders
- ✓ Information & observations re: child:
- ❑ Development stage; temperament
- ❑ Appearance, injuries, condition
- ❑ Daily routine & any differences
- ❑ Family & health status information
- ✓ Describe outdoor/indoor environment: ***Measure, diagram, photos & videos***
- ❑ Area layout; sleeping conditions
- ❑ Cleanliness, temperature, odors
- ❑ Bedding, food, drugs/alcohol
- ❑ Furniture, stairway(s), toys, etc.
- ✓ Obtain vital & accessible information:
- ❑ EMS run sheets; crime scene log
- ❑ Criminal records; 911 call logs
- ❑ CPS records; licensed facility logs
- ❑ Medical & search consent
- ❑ Medical history & records

How:

Gather evidence carefully and** objectively. Lay a foundation for **determining what happened.

- ✓ Arrive as soon as possible
- ✓ Composed demeanor & approach:
  - ❑ Be calm - Acknowledge emotion, stress
  - ❑ Establish rapport
  - ❑ Ask comprehensive questions
- ✓ Call on a *pre-determined* multidisciplinary team ASAP: **EMS, Law Enforcement (LE), CPS, other local resources**
- ✓ Ensure a quick response time- avoid leaving messages
- ✓ Follow established checklists/ protocols (SUIDI, child abuse investigation, etc.)
- ✓ Consider prior experience & cases: What works/ doesn't?

- ✓ Don't assume innocence **or** culpability
  - ❑ Treat every scene as a *potential* crime scene
  - ❑ Demonstrate respect, sensitivity, neutrality: be non-judgmental
- ✓ Separate people and interview ASAP *(get specialized interview training)*
  - ❑ Convey that a full, careful investigation is standard procedure
  - ❑ Open, non-confrontational questions ("What happened?")
  - ❑ Let people talk: record verbatim
- ✓ Photos/videos – record as much as possible! *(get equipment training)*
  - ❑ Show scale in photos to indicate color and measurement
  - ❑ **Ask witness(es) to describe & reconstruct what happened:** record w/ video *(possibly use doll)*
  - ❑ Document any changes to child & scene (*e.g., body or items moved)*
- ✓ **LE**: If at all possible, attend & observe autopsy, collect relevant evidence

Sudden Unexplained Infant Death Investigations

SUIDI Pathologist Summary*

Medical examiners consider this scene/case information critical to determining the cause & manner of death. It should be collected and presented to the forensic pathologist *before* the autopsy is conducted.

Does preliminary investigation indicate any of the following?

SLEEPING ENVIRONMENT

- ❒ **Asphyxia** *(e.g., overlying, wedging, choking, nose/mouth obstruction, re-breathing, neck compression, immersion in water)*
- ❒ **Shared sleeping surfaces** *(with adults, children, pets)*
- ❒ **Change in sleeping conditions** *(e.g., unaccustomed stomach sleep position, location, or sleep surface)*
- ❒ **Hyperthermia/hypothermia** *(e.g., excessive wrapping, blankets, clothing, hot or cold environments)*
- ❒ **Environmental hazards** *(e.g., chemicals, drugs, carbon monoxide, noxious gases, devices)*
- ❒ **Unsafe sleeping conditions** *(e.g., couch/sofa, waterbed, stuffed toys, pillows, soft bedding)*

INFANT HISTORY

- ❒ **Diet concerns** *(e.g., solids introduction)*
- ❒ **Recent hospitalization(s)**
- ❒ **Previous medical diagnosis**
- ❒ **History of acute life-threatening events** *(ALTEs: e.g., apnea, seizures, difficulty breathing)*
- ❒ **History of medical care without diagnosis**
- ❒ **Recent fall or other injury**
- ❒ **History of religious, cultural or ethnic remedies**
- ❒ **Cause of death due to natural causes other than SIDS** *(e.g., birth defects, complications of preterm birth)*

FAMILY INFORMATION

- ❒ **Prior sibling deaths**
- ❒ **Previous encounter(s) with police and/or social service agencies**
- ❒ **Request for organ and/or tissue donation**
- ❒ **Objection to autopsy**

EXAM

- ❒ **Pre-terminal resuscitative treatment rendered**
- ❒ **Death due to trauma *(injury)*, poisoning, or intoxication**

INVESTIGATOR INSIGHTS

- ❒ **Suspicious circumstances**
- ❒ **Other alerts for pathologist's attention**

**This information is from the CDC's Sudden Unexplained Infant Death Investigation (SUIDI) Reporting Form.*

Emergency Medical Professionals

Responding to Sudden Unexpected Child Death or Serious Injury

1. ***Insure safety and provide medical aid as needed to save or assist the child***
2. **If child is clearly dead, do not move the body**
   - Be careful not to destroy potential evidence
   - For an infant who has died, complete EMS portion of SUIDI Reporting Form
3. **Make sure Law Enforcement has been notified (whether you stay at the scene or not)**
   - Provide your contact info to Law Enforcement
4. **Document all adults and children present**
   - Include who has left
   - What they did and said; their appearance
   - Their reactions to child's death or injury
5. **Document all statements and demeanor (emotional state) of speakers**
   - ASAP and verbatim
   - Explain your job is to provide medical aid
   - Ask for caretaker explanation; request details
   - Record observations of both words & actions
6. **Document all your observations of the environment ASAP**
   - Focus all your senses on the surroundings
   - Describe scene accurately & completely
   - Possible mechanism of injury present?
7. **Consider & record child's developmental level**
   - Compare reasonableness of history given regarding mechanism of injury to child's age & developmental abilities and scene observations
8. **Know signs of possible abuse & neglect:**
   - ***Physical abuse:*** Unexplained broken bones, bruises, black eyes, cuts, burns, welts; pattern injuries, bite marks; reports of injury received from an adult caretaker, etc.
   - ***Sexual abuse:*** Difficulty walking or sitting, inappropriate interest or knowledge of sexual acts, reports of inappropriate touching, etc.
   - ***Neglect:*** Obvious lack of hygiene; back of head flat; severe diaper rash; hungry; underweight; lack of food, formula or care; parent or child use of drugs or alcohol, etc.
9. **Notify CPS to report any suspicion of abuse or neglect of any child present at the scene**
   - CPS 24 hour Central Intake: **800-562-5624**
   - MedCon expert consultation: **800-326-5300**
10. **Participate in local multidisciplinary team (MDT) meetings to review child abuse cases**

References: CPOD 1st Responder Guidelines training – Gary Sacha; Update, vol. 17, no. 7, Laura Rogers (2004)

Produced in 2006 by the WA State Criminal Justice Training Commission (CJTC) with DSHS CJA funding

For additional resources & training information, consult www.cjtc.state.wa.us or contact CJTC Program Manager Patti Toth at ptoth@cjtc.state.wa.us

APPENDIX II: PROTOCOL UPDATE & REVISION CONTRIBUTORS

2008 PROTOCOL COMMITTEE PARTICIPANTS
(Alpha Order)

- Roxy Barnes, City of Vancouver Fire Department
- Commissioner Marc Boldt, Clark County
- Mary Blanchette, Director of the Children's Justice Center (CJC)
- Special Investigator Carol Buck, City of Camas Police Department
- Sergeant David Chaney, City of Camas Police Department
- Chief Clifford Cook, City of Vancouver Police Department
- Nikki Costa, Clark County Medical Examiner Manager
- Arthur D. Curtis, Clark County Prosecuting Attorney
- Chief Mike Evans, Clark County Sheriff's Office
- Kim Farr, Senior Deputy Prosecuting Attorney
- Chief Carrie Green, City of Ridgefield Police Department
- Sergeant Rex Gunderson, City of Vancouver Police Department
- Lieutenant Andy Hamlin, City of Vancouver Police Department
- Dr. Jason Hanley, Southwest Washington Medical Center Emergency Department
- Cindy Hardcastle, State of Washington Dept. of Children and Family Services Area Manager
- Mary Herdener, CJC Program Coordinator
- Pat Jollota, City of Vancouver Council Members
- Kristin Lince, Attorney General's Office
- Sheriff Garry Lucas, Clark County Sheriff's Office
- Linda Moorehead, Humane Society
- Joan Renner, YWCA Director of the Sexual Assault Program
- Mike Shea, Dept. of Children and Family Services Child Protective Service Supervisor
- Doug Smith, CRESA
- Helen Sullivan, Dept. of Children and Family Services Child Protective Service Supervisor
- Art Tolentino, Columbia River Mental Health
- Chuck Tourtillott, Humane Society
- Connie Utterback, Legal Secretary
- Dennis J. Wickham M.D., Clark County Medical Examiner
- Dr. Lynn K. Wittwer, Clark County Medical Program Director

2010 PROTOCOL COMMITTEE PARTICIPANTS (MINOR SEX TRAFFICKING UPDATE)
(*Amendments to this protocol on pages 6, 16 & 17*):
(Alpha Order)

- Kevin Allais, Clark County Sheriff's Office Sergeant
- Pat Beckett, Children's Center Director
- Beth Best, Southwest Washington Medical Center Emergency Department
- John Chapman, Vancouver Police Department Lieutenant
- Mike Cooke, Clark County Sheriff's Office Commander
- Eric Gilman, Clark County Juvenile Justice Program Manager
- Duncan Hoss, Clark County Sheriff's Office Sergeant
- Cindy Hardcastle, State of Washington Dept. of Children and Family Services Area Manager
- Kai Hill, YWCA Sexual Assault Program Advocate
- Scott Jackson, Clark County Senior Deputy Prosecuting Attorney
- Anna Klein, Clark County Deputy Prosecuting Attorney
- Kira Lewis Carter, State of Washington Dept. of Children and Family Services Social Worker
- Jeff McCarty, Clark County Deputy Prosecuting Attorney
- Tim Oberheide, Clark County Juvenile Justice Detention Manager
- Joan Renner, YWCA the Sexual Assault Program Director
- Kelli Russell, Clark County Juvenile Justice Detention Officer
- Gary Spaulding, Vancouver Police Department Sergeant
- Helen Sullivan, State of Washington Dept. of Children and Family Services Supervisor
- Barbe West, Free Clinic of Southwest Washington Executive Director
- Penny Wilson, Cowlitz Tribe Pathways to Healing Program Advocate

Leadership sign-off for this revision included the following (alpha order)**:**

- Marc Boldt, Clark County Commissioner
- Pat Beckett, Children's Center Director
- Chief Clifford Cook, City of Vancouver Police Department
- Dr. Randy Copeland, Legacy Salmon Creek Child Abuse Assessment Clinic Pediatrician
- Dr. Kim Copeland, Legacy Salmon Creek Child Abuse Emergency Department
- Arthur D. Curtis, Clark County Prosecuting Attorney
- Pat Escamilla, Juvenile Court Director
- Chief Carrie Greene, City of Ridgefield Police Department
- Chief Ron Mitchell, City of Washougal Police Department
- Chief Tim Hopkin, City of La Center Police Department
- Cindy Hardcastle, State of Washington Division of Children and Families Area Manager
- Bart Hanson, Vancouver City Council Member
- Louise Jenkins, Southwest Washington Emergency Department Manager
- Kristin Lince, State of Washington Assistant Attorney General's Office
- Sheriff Garry Lucas, Clark County Sheriff's Office
- Chief Robert Carden, City of Battle Ground Police Department.
- Joan Renner, YWCA Sexual Assault Program Director
- Marsha Stover, PNP, Child Abuse Examiner (private practitioner)
- Janet Saunders, Legacy Salmon Creek Hospital Director of Children's Services

- Barbe West. Free Clinic of Southwest Washington Executive Director
- Debbie Maderios, Cowlitz Tribe Pathways to Healing Program Manager

2016 PROTOCOL UPDATE PARTICIPANTS AND REVIEWERS
(Alpha Order)

- Sheriff Chuck Atkins, Clark County Sheriff's Office
- Chief Dan Bellini, City of Woodland Police Department
- Mary Blanchette, CJC Executive Director
- Marc Bolt, CJC Executive Board Member/Clark County Councilor Chair
- Lisa Carpenter, Family Solutions Mental Health Supervisor
- Kim Christly, CJC Forensic Interviewer
- Dr. Kim Copeland, Legacy Salmon Creek Child Abuse Assessment Team, Site Medical Director
- Chief Marc Denny, City of La Center Police Dept.
- Pat Escamilla, Juvenile Court Director
- Tony Golik, Clark County Prosecutor
- Jerry Green, Clark County Fire District 6*
- Chief Carrie Greene, City of Ridgefield Police Dept.
- Dr. Jason Hanley, Peace Health Medical Director*
- Bart Hansen, CJC Board Member/Vancouver City Councilor
- Cindy Hardcastle, DSHS Dept. of Children and Family Services
- Colin Hayes, Clark County Lead Deputy Prosecuting Attorney
- Sgt. Barbara Kipp, Vancouver Police Department
- Chief Mitch Lackey, City of Camas Police Dept.*
- Dr. Lisa Lyons, Salmon Creek Medical Center Manager
- Chief McElvain, Vancouver Police Department Chief
- Chief Ron Mitchell, City of Washougal Police Dept.*
- Joe Molina, Vancouver Fire Department Chief*
- Deedee Pegler, CJC Lead Victim Advocate
- Ben Peeler, Director North Country EMS*
- Anna Pendergrass, Clark County Regional Service Agency (CRESA)*
- Renata Rhodes, DSHS Child Protective Service Supervisor
- Chief Bob Richardson, City of Battle Ground Police Department *
- Helen Sullivan, Children's Center Mental Health
- Sarra Yamin, State of Washington Assistant Attorney General's Office
- Dr. Dennis J. Wickham, M.D., Clark County Medical Examiner

*NOTE: Review only

Reporting Form SUIDI

Sudden Unexp ained nfant Death nvestigation

INVESTIGATION DATA

Infant's Information: Last: _____ First: _____ M. ____ Case#_____

Sex: ☐ Male ☐ Female Date of Birth____/____/____ Age_____ SS#_____
Month Day Year

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

Infant's Primary Residence Address:

Address _____ City _____ Zip _____

Incident Address:

Address _____ City _____ Zip _____

Contact Information for Witness:

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

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

Last _____ First _____ M. _____ SS# _____

Home Address _____ City _____ State _____ Zip _____

Place of Work _____ City _____ State _____ Zip _____

Phone (H) _____ Phone (W) _____ Date of Birth _____

WITNESS INTERVIEW

1. Are you the usual caregiver? ☐ Yes ☐ No _____
2. Tell me what happened:

_____

_____

_____

3. Did you notice anything unusual or different about the infant in the last 24 hrs? ☐ No ☐ Yes ⇨ Describe: _____

_____

4. Did the infant experience any falls or injury within the last 72 hrs? ☐ No ☐ Yes ⇨ Describe: _____
5. When was the infant LAST PLACED? ..... ____/____/____ ____:____ _____
Month Day Year Military Time Location (room)
6. When was the infant ***LAST KNOWN ALIVE (LKA)***? ____/____/____ ____:____ _____
Month Day Year Military Time Location (room)
7. When was the infant ***FOUND***? .... ____/____/____ ____:____ _____
Month Day Year Military Time Location (room)
8. Explain how you knew the infant was still alive. _____
9. Where was the infant - (P)laced, (L)ast known alive, (F)ound (circle P, L, or F in front of appropriate response)?

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

P L F Other _____

WITNESS INTERVIEW (cont.)

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

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

12 **In what position was the infant *Found*?** ☐ Sitting ☐ On back ☐ On side ☐ On stomach ☐ Unknown
Was this the infant's usual position? ☐ Yes ☐ No ⇨ What was the infant's usual position? _____

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

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

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

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

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

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

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

20 **Was the infant tightly wrapped or swaddled?** ☐ No ☐ Yes ⇨ Describe: _____

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

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

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

23 What was the temperature of the infant's room? ☐ Hot ☐ Cold ☐ Normal ☐ Other _____

24 What was the infant's temperature? _____

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

26 Which of the following items were within the infant's reach? ☐ Blankets ☐ Toys ☐ Pillows
☐ Pacifier ☐ Nothing ☐ Other _____

27 Was anyone sleeping with the infant? ☐ No ☐ Yes ⇨ Name these people.

Name	Age	Height	Weight	Location in Relation to Infant	Impaired (intoxicated, tired)

28 Was there evidence of wedging? ☐ No ☐ Yes ⇨ Discribe: _____

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

WITNESS INTERVIEW (cont.)

30 **What had led you to check on the infant?** _____

31 **Describe infant's appearance when found.**

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

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

☐ Sweaty ☐ Warm to touch ☐ Cool to touch
☐ Limp, flexible ☐ Rigid, stiff ☐ Unknown
☐ Other ⇨Specify: ..... _____

33 **Did anyone else other than EMS try to resuscitate the infant?** ☐ No ☐ Yes ⇨Who and when?

Who _____ ___/___/___ ___:___
Month Day Year Military Time

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

_____

_____

_____

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

_____

INFANT MEDICAL HISTORY

1 **Source of medical information:** ☐ Doctor ☐ Other healthcare provider ☐ Medical record
☐ Mother/primary caregiver ☐ Family ☐ Other:

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

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

3 **In the 72 hours prior to death, was the infant injured or did s/he have any other condition(s) not mentioned?**
☐ No ☐ Yes ⇨Describe: _____

4 **In the 72 hours prior to the infants death, was the infant given any vaccinations or medications?**
(Please include any home remedies, herbal medications, prescription medicines, over-the-counter medications.)

☐ No ☐ Yes ⇨List below

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

INFANT MEDICAL HISTORY (cont.)

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

	Unknown	No	Yes	Discribe:
a) Allergies (food, medication, or other)	☐	☐	☐ ⇨	_____
b) Abnormal growth or weight gain/loss	☐	☐	☐ ⇨	_____
c) Apnea (stopped breathing)	☐	☐	☐ ⇨	_____
d) Cyanosis (turned blue/gray)	☐	☐	☐ ⇨	_____
e) Seizures or convulsions	☐	☐	☐ ⇨	_____
f) Cardiac (heart) abnormalities	☐	☐	☐ ⇨	_____
g) Metabolic disorders	☐	☐	☐ ⇨	_____
h) Other	☐	☐	☐ ⇨	_____

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

Describe: _____

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

	First most recent visit	Second most recent visit
a) Date	___/___/___ (Month Day Year)	___/___/___ (Month Day Year)
b) Reason for visit	_____	_____
c) Action taken	_____	_____
d) Physician's name	_____	_____
e) Hospital/clinic	_____	_____
f) Address	_____	_____
g) City, ZIP	_____	_____
h) Phone number	( ) - _____	( ) - _____

8 **Birth hospital name:**

Street

City _____ State _____ ZIP _____

Date of discharge ___/___/___ (Month Day Year)

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

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

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

☐ On time ☐ Early - How many weeks early? ☐ Late - How many weeks late? _____

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

☐ Singleton ☐ Twins ☐ Triplet ☐ Quadruplet or higher gestation

13 **Were there any complications during delivery or at birth?** *(emergency c-section, child needed oxygen)*

☐ No ☐ Yes ⇨Describe the complications: _____

_____

_____

14 **Are there any alerts to pathologist?** *(previous infant deaths in family, newborn screen results)*

☐ No ☐ Yes ⇨Specify: _____

_____

_____

INFANT DIETARY HISTORY

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

____/____/____ (Month / Day / Year) ____:____ (Military Time)

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

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

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

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

5 **Was a new food introduced in the 24 hours prior to his/her death?**

☐ No ☐ Yes ⇨Describe *(ex. content, amount, change in formula, introduction of solids)*

_____

_____

_____

6 **Was the infant last placed to sleep with a bottle?**

☐ Yes ☐ No ⇨Skip to question **9** below

7 **Was the bottle propped?** *(i.e., object used to hold bottle while infant feeds)*

☐ No ☐ Yes ⇨ What object was used to prop the bottle? _____

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

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

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

☐ No ☐ Yes ⇨ Discribe concerns: _____

_____

_____

_____

PREGNANCY HISTORY

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

First name _____ Middle name _____

Last name _____ Maiden name _____

Date of birth: ____/____/____ (Month / Day / Year) SS # ____-____-____

Current Address _____ City _____ State ____ ZIP ____

How long has the birth mother been a resident at this address? ____ Years and ____ Months

Previous Address ____ City ____ State ____

2 **At how many weeks or months did the birth mother begin prenatal care?**

____ Weeks ____ Months ☐ No prenatal care ☐ Unknown

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

Physician/provider _____ Hospital/clinic _____ Phone (___) ___-____

Street _____ City _____ State _____ ZIP _____

PREGNANCY HISTORY (cont.)

4 **During her pregnancy with the infant, did the biological mother have any complications?**
(ex. high blood pressure, bleeding, gestational diabetes)

☐ No ☐ Yes ⇨ Specify _____

5 **Was the biological mother injured during her pregnancy with the infant?** *(ex. auto accident, falls)*

☐ No ☐ Yes ⇨ Specify _____

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

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

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

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

INCIDENT SCENE INVESTIGATION

1 **Where did the incident or death occur?** _____

2 **Was this the primary residence?** ☐ Yes ☐ No

3 **Is the site of the incident or death scene a daycare or other childcare setting?**

☐ Yes ☐ No ⇨Skip to question **8** below

4 **How many children were under the care of the provider at the time of the incident or death?** _____ *(under 18 years or older)*

5 **How many adults were supervising the child(ren)?** _____ *(18 years or older)*

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

License number: _____ Agency: _____

7 **How long has the daycare been open for business?** _____

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

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

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

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

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

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

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

☐ Public/municipal water source ☐ Bottled water ☐ Other ⇨Specify _____
☐ Well ☐ Unknown

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

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

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

_____

_____

INVESTIGATION SUMMARY

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

_____

2 **Arrival times:** **Law enforcement at scene:** _____ : _____ (Military Time) **DSI at scene:** _____ : _____ (Military Time) **Infant at hospital:** _____ : _____ (Military Time)

Investigator's Notes

Indicate the task(s) performed.

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

If more than one person was interviewed, does the information differ?

☐ No ☐ Yes ⇨Detail any differences, inconsistencies of relevant information: (ex. placed on sofa, last known alive on chair.)

_____

_____

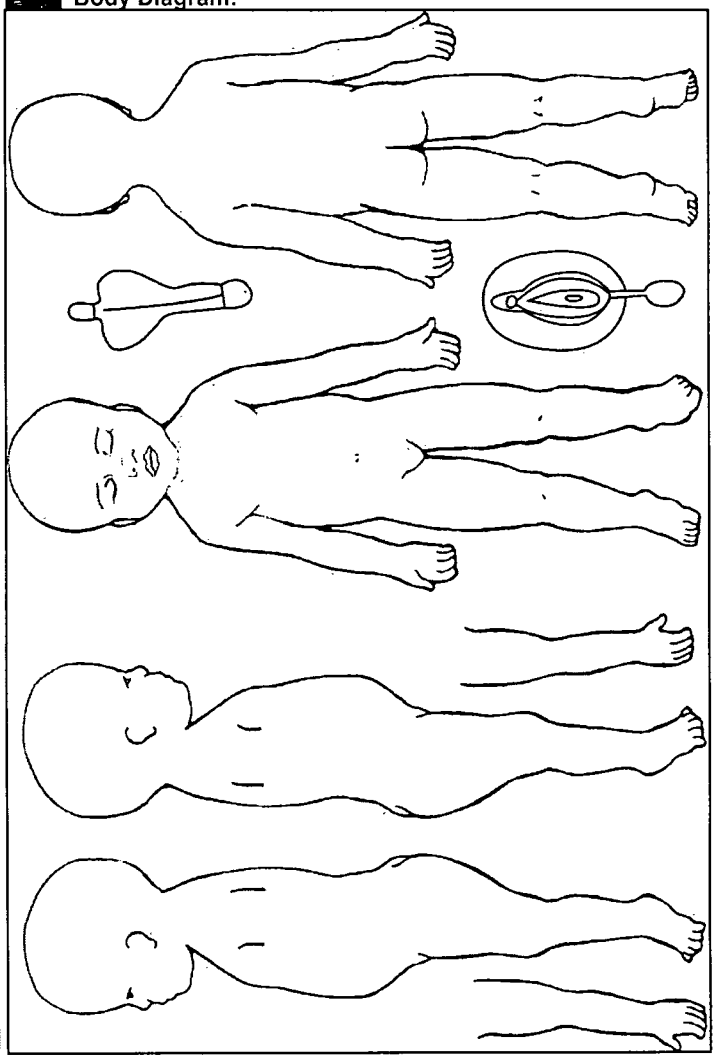
_____

_____

INVESTIGATION DIAGRAMS

1 **Scene Diagram:**

2 **Body Diagram:**



SUMMARY FOR PATHOLOGIST

Case Information

Investigator Information: Name _____ Agency _____ Phone _____

Investigated: ____/____/____ ____:____ Pronounced Dead: ____/____/____ ____:____
Month Day Year Military Time Month Day Year Military Time

Infant's Information: Last _____ First _____ M. _____ Case # _____

Sex: ☐ Male ☐ Female Date of Birth ____/____/____ Age _____
Month Day Year Months

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

Sleeping Environment

1 Indicate whether preliminary investigation suggests any of the following:

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

Infant History

☐	☐	Diet *(e.g., solids introduction etc.)*
☐	☐	Recent hospitalization
☐	☐	Previous medical diagnosis
☐	☐	History of acute life-threatening events *(ex. apnea, seizures, diffi culty breathing)*
☐	☐	History of medical care without diagnosis
☐	☐	Recent fall or other injury
☐	☐	History of religious, cultural, or ethnic remedies
☐	☐	Cause of death due to natural causes other than SIDS *(ex. birth defects, complications of preterm birth)*

Family Info

☐	☐	Prior sibling deaths
☐	☐	Previous encounters with police or social service agencies
☐	☐	Request for tissue or organ donation
☐	☐	Objection to autopsy

Exam

☐	☐	Pre-terminal resuscitative treatment
☐	☐	Death due to trauma (injury), poisoning, or intoxication

Investigator Insight

☐	☐	Suspicious circumstances
☐	☐	Other alerts for pathologist's attention

Any "Yes" answers should be explained and detailed.

Brief description of circumstances: _____

Pathologist

2 Pathologist Information:

Name _____ Agency _____

Phone (_____) _____ - _____ Fax (_____) _____ - _____

APPENDIX II: PROTOCOL UPDATE & REVISION CONTRIBUTORS

2008 PROTOCOL COMMITTEE PARTICIPANTS
(Alpha Order)

- Roxy Barnes, City of Vancouver Fire Department
- Commissioner Marc Boldt, Clark County
- Mary Blanchette, Director of the Children's Justice Center (CJC)
- Special Investigator Carol Buck, City of Camas Police Department
- Sergeant David Chaney, City of Camas Police Department
- Chief Clifford Cook, City of Vancouver Police Department
- Nikki Costa, Clark County Medical Examiner Manager
- Arthur D. Curtis, Clark County Prosecuting Attorney
- Chief Mike Evans, Clark County Sheriff's Office
- Kim Farr, Senior Deputy Prosecuting Attorney
- Chief Carrie Green, City of Ridgefield Police Department
- Sergeant Rex Gunderson, City of Vancouver Police Department
- Lieutenant Andy Hamlin, City of Vancouver Police Department
- Dr. Jason Hanley, Southwest Washington Medical Center Emergency Department
- Cindy Hardcastle, State of Washington Dept. of Children and Family Services Area Manager
- Mary Herdener, CJC Program Coordinator
- Pat Jollota, City of Vancouver Council Members
- Kristin Lince, Attorney General's Office
- Sheriff Garry Lucas, Clark County Sheriff's Office
- Linda Moorehead, Humane Society
- Joan Renner, YWCA Director of the Sexual Assault Program
- Mike Shea, Dept. of Children and Family Services Child Protective Service Supervisor
- Doug Smith, CRESA
- Helen Sullivan, Dept. of Children and Family Services Child Protective Service Supervisor
- Art Tolentino, Columbia River Mental Health
- Chuck Tourtillott, Humane Society
- Connie Utterback, Legal Secretary
- Dennis J. Wickham M.D., Clark County Medical Examiner
- Dr. Lynn K. Wittwer, Clark County Medical Program Director

2010 PROTOCOL COMMITTEE PARTICIPANTS (MINOR SEX TRAFFICKING UPDATE)
(*Amendments to this protocol on pages 6, 16 & 17*):
(Alpha Order)

- Kevin Allais, Clark County Sheriff's Office Sergeant
- Pat Beckett, Children's Center Director
- Beth Best, Southwest Washington Medical Center Emergency Department
- John Chapman, Vancouver Police Department Lieutenant
- Mike Cooke, Clark County Sheriff's Office Commander
- Eric Gilman, Clark County Juvenile Justice Program Manager
- Duncan Hoss, Clark County Sheriff's Office Sergeant
- Cindy Hardcastle, State of Washington Dept. of Children and Family Services Area Manager
- Kai Hill, YWCA Sexual Assault Program Advocate
- Scott Jackson, Clark County Senior Deputy Prosecuting Attorney
- Anna Klein, Clark County Deputy Prosecuting Attorney
- Kira Lewis Carter, State of Washington Dept. of Children and Family Services Social Worker
- Jeff McCarty, Clark County Deputy Prosecuting Attorney
- Tim Oberheide, Clark County Juvenile Justice Detention Manager
- Joan Renner, YWCA the Sexual Assault Program Director
- Kelli Russell, Clark County Juvenile Justice Detention Officer
- Gary Spaulding, Vancouver Police Department Sergeant
- Helen Sullivan, State of Washington Dept. of Children and Family Services Supervisor
- Barbe West, Free Clinic of Southwest Washington Executive Director
- Penny Wilson, Cowlitz Tribe Pathways to Healing Program Advocate

Leadership sign-off for this revision included the following (alpha order)**:**

- Marc Boldt, Clark County Commissioner
- Pat Beckett, Children's Center Director
- Chief Clifford Cook, City of Vancouver Police Department
- Dr. Randy Copeland, Legacy Salmon Creek Child Abuse Assessment Clinic Pediatrician
- Dr. Kim Copeland, Legacy Salmon Creek Child Abuse Emergency Department
- Arthur D. Curtis, Clark County Prosecuting Attorney
- Pat Escamilla, Juvenile Court Director
- Chief Carrie Greene, City of Ridgefield Police Department
- Chief Ron Mitchell, City of Washougal Police Department
- Chief Tim Hopkin, City of La Center Police Department
- Cindy Hardcastle, State of Washington Division of Children and Families Area Manager
- Bart Hanson, Vancouver City Council Member
- Louise Jenkins, Southwest Washington Emergency Department Manager
- Kristin Lince, State of Washington Assistant Attorney General's Office
- Sheriff Garry Lucas, Clark County Sheriff's Office
- Chief Robert Carden, City of Battle Ground Police Department.
- Joan Renner, YWCA Sexual Assault Program Director
- Marsha Stover, PNP, Child Abuse Examiner (private practitioner)
- Janet Saunders, Legacy Salmon Creek Hospital Director of Children's Services

- Barbe West. Free Clinic of Southwest Washington Executive Director
- Debbie Maderios, Cowlitz Tribe Pathways to Healing Program Manager

2016 PROTOCOL UPDATE PARTICIPANTS AND REVIEWERS
(Alpha Order)

- Sheriff Chuck Atkins, Clark County Sheriff's Office
- Chief Dan Bellini, City of Woodland Police Department
- Mary Blanchette, CJC Executive Director
- Marc Bolt, CJC Executive Board Member/Clark County Councilor Chair
- Lisa Carpenter, Family Solutions Mental Health Supervisor
- Kim Christly, CJC Forensic Interviewer
- Dr. Kim Copeland, Legacy Salmon Creek Child Abuse Assessment Team, Site Medical Director
- Chief Marc Denny, City of La Center Police Dept.
- Pat Escamilla, Juvenile Court Director
- Tony Golik, Clark County Prosecutor
- Jerry Green, Clark County Fire District 6*
- Chief Carrie Greene, City of Ridgefield Police Dept.
- Dr. Jason Hanley, Peace Health Medical Director*
- Bart Hansen, CJC Board Member/Vancouver City Councilor
- Cindy Hardcastle, DSHS Dept. of Children and Family Services
- Colin Hayes, Clark County Lead Deputy Prosecuting Attorney
- Sgt. Barbara Kipp, Vancouver Police Department
- Chief Mitch Lackey, City of Camas Police Dept.*
- Dr. Lisa Lyons, Salmon Creek Medical Center Manager
- Chief McElvain, Vancouver Police Department Chief
- Chief Ron Mitchell, City of Washougal Police Dept.*
- Joe Molina, Vancouver Fire Department Chief*
- Deedee Pegler, CJC Lead Victim Advocate
- Ben Peeler, Director North Country EMS*
- Anna Pendergrass, Clark County Regional Service Agency (CRESA)*
- Renata Rhodes, DSHS Child Protective Service Supervisor
- Chief Bob Richardson, City of Battle Ground Police Department *
- Helen Sullivan, Children's Center Mental Health
- Sarra Yamin, State of Washington Assistant Attorney General's Office
- Dr. Dennis J. Wickham, M.D., Clark County Medical Examiner

*NOTE: Review only