BY ORDER OF THE COMMANDER, 15TH AIRLIFT WING

15TH AIRLIFT WING INSTRUCTION 40-301

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Medical Command

FAMILY ADVOCACY PROGRAM

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

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This instruction implements Air Force Instruction 40-301, Family Advocacy, and establishes responsibilities and procedures for the Family Advocacy Program (FAP). It provides procedures for identification, protection, treatment, and prevention of family maltreatment as well as identification and case management of family members with exceptional needs. This instruction requires the identification of exceptional family members of Air Force personnel on active duty and mandates reporting of all incidents of family maltreatment by all base organizational units. This instruction applies to all active duty members and to US Air Force Reserve and Air National Guard units and their personnel.

SUMMARY OF REVISIONS

15 AWI 40-301 has been substantially revised and should be reviewed thoroughly as a result of recent implementation of expanded maltreatment definitions in the Air Force and the importance of accurate installation directives.

Chapter 1

GENERAL

1.1. Concept of Operation. Family Advocacy support to the 15th Airlift Wing and units assigned, attached, or associated with the 15 AW is provided by the 15th Medical Group, Family Advocacy Program at Hickam AFB, Hawaii. The Family Advocacy Program (FAP) applies to all active duty members assigned, attached, or associated to the 15 AW including all tenant units. The FAP provides prevention and treatment of family maltreatment through outreach and family assessments, along with identification and case management of family members with exceptional needs. It assigns responsibilities and explains procedures for the management of the FAP. This instruction requires the identification of special needs family members of Air Force personnel on active duty and mandates reporting of all incidents of family maltreatment by all base organizational units. This instruction applies to all base organizational units and active duty members, Air Reserve Components and Air National Guard units.

1.2. Definition of Terms.

1.2.1. Child. An unmarried person under the age of 18 who is eligible for care through a DoD medical treatment program and for whom a parent, guardian, foster parent, caregiver, employee of a residential facility, or any staff person providing out-of-home care is legally responsible. The term "child" means a biological child, adopted child, stepchild, foster child, or ward. The term also includes an individual of any age who is incapable of self-support because of a mental or physical incapacity and for who care in a military medical treatment program is authorized.

1.2.2. Spouse. An individual who is married and:(1)a service member,(2)employed by DoD and eligible for care through DoD medical treatment programs, or (3)a civilian who is eligible for care through DoD medical treatment programs because of marriage to a service member, or to an employee of DoD who is eligible for care through DoD medical treatment programs. This includes a married individual who is under 18 years of age.

1.2.3. Alleged Offender. Any person, who causes the maltreatment of a child while in a caretaker role, or the maltreatment of his/her spouse, or whose act, or failure to act, substantially impaired the health or well-being of the victim. Exception exists in cases of child sexual maltreatment when the alleged offender may not be in a caretaker role but was in a position of power over the victim.

1.2.4. Caregiver. An individual or group of individuals in a position of responsibility for the temporary or permanent care/supervision of a minor or a person of any age who is incapable of self-support because of a developmental or physical challenge (special needs adult). Such care and/or supervision may be provided in the child’s home, in a military sanctioned caregiver’s home, at a military sponsored or military sanctioned out-of-home care facility or a residential facility, or in an activity conducted at various locations. They are of three different types:

1.2.4.1. A family member. An individual who is related by blood, law, or marriage to the child or special needs adult for whom he or she is providing care.

1.2.4.2. Extra familial caregiver. The classification of an alleged offender is unrelated to the victim by blood, law, or marriage, (i.e.outside of the victim's family) and who is an employee (including janitors, bus drivers, etc.), independent contractor, or volunteer in a military-sanctioned or military-sponsored program that provides care for and supervision of a child by agreement with the child's parent guardian, or foster parent. Such care and supervision maybe provided in the

child's home, in a military-sanctioned caregiver's home, at a military-sponsored or military-sanctioned out-of-home care facility or residential facility, or in an activity conducted at various locations.

1.2.4.3. Extra familial caregiver/power role (DoD Non-Sanctioned*)*. This category is for extra-familial caregivers where there are allegations of child sexual abuse, and the caregiver was not in a DoD sanctioned role or activity. Also included are extra-familial offenders in a position of power over the alleged victim, and the offender was not in a DoD-sanctioned caregiver role or activity. Caregivers may be active duty members or their family members; retirees, or their family members; civilians, or juveniles in a position of power.

1.2.5. Child Maltreatment. See **Attachment 2**, Air Force Family Advocacy Program Family Maltreatment Definitions.

1.2.6. Child Physical Maltreatment. See **Attachment 2**, Air Force Family Advocacy Program Family Maltreatment Definitions.

1.2.7. Child Emotional Maltreatment. See **Attachment 2**, Air Force Family Advocacy Program Family Maltreatment Definitions.

1.2.8. Child Neglect. See **Attachment 2**, Air Force Family Advocacy Program Family Maltreatment Definitions.

1.2.8.1. Abandonment. Neglect in which the caregiver is absent and does not intend to return or is away from home for an extended period without having arranged for an appropriate surrogate caregiver.

1.2.8.2. Deprivation of necessities. Neglect that includes the failure to provide appropriate nourishment, shelter and clothing.

1.2.8.3. Educational neglect. See **Attachment 2**, Air Force Family Advocacy Program Family Maltreatment Definitions.

1.2.8.4. Lack of supervision. See **Attachment 2**, Air Force Family Advocacy Program Family Maltreatment Definitions.

1.2.8.5. Medical neglect. Neglect in which a parent or guardian refuses or fails to provide appropriate, medically necessary health care, (medical, mental health, dental) for the child although the parent is financially able to do so or was offered other means to do so.

1.2.8.6. Non-organic failure to thrive (FTT). A type of child neglect which manifests itself in an infant's or young child's failure to grow and develop when no organic basis for this deviation is found. Usually such children register below the third percentile in height and weight.

1.2.9. Child Sexual Maltreatment. See **Attachment 2**, Air Force Family Advocacy Program Family Maltreatment Definitions.

1.2.9.1. Exploitation. See **Attachment 2**, Air Force Family Advocacy Program Family Maltreatment Definitions.

1.2.9.2. Molestation. See **Attachment 2**, Air Force Family Advocacy Program Family Maltreatment Definitions.

1.2.9.3. Rape/Intercourse. See **Attachment 2**, Air Force Family Advocacy Program Family Maltreatment Definitions.

1.2.9.4. Other sexual maltreatment. See **Attachment 2**, Air Force Family Advocacy Program Family Maltreatment Definitions.

1.2.9.5. Child sexual maltreatment in DoD-Sanctioned activities (formerly termed “Out-of Home”). Any child sexual maltreatment occurring during DoD-sanctioned activity in any location where the military service has sanctioned or authorized care of children by individuals other than their legal guardians. Examples include: CDCs, DoDEA schools, buses, recreation facilities, Licensed Home Day Care Facilities, DoD sponsored Boy/Girl Scout functions, Base Chapel, or locations where Red Cross trained baby-sitting occurs.

1.2.10. Spouse Emotional Maltreatment. See **Attachment 2**, Air Force Family Advocacy Program Family Maltreatment Definitions.

1.2.11. Spouse Physical Abuse/Maltreatment. See **Attachment 2**, Air Force Family Advocacy Program Family Maltreatment Definitions

1.2.12. Spouse Sexual Abuse/Maltreatment. See **Attachment 2**, Air Force Family Advocacy Program Family Maltreatment Definitions

1.2.13. Spouse Neglect. See **Attachment 2**, Air Force Family Advocacy Program Family Maltreatment Definitions

1.2.14. Incident Status Determination. The clinical status of the incident as determined by the Family Maltreatment Case Management Team. This includes "Met Criteria” and “Did Not Meet Criteria”.

1.2.14.1. Did Not Meet Criteria. A designation that indicates an alleged incident of child or spouse maltreatment has been clinically determined by the FMCMT to be without merit or foundation, or that the preponderance of the available information did not meet the Air Force definitions.

1.2.14.2. Met Criteria. A designation that indicates an alleged incident of child or spouse abuse or maltreatment has been clinically determined by the FMCMT to be merited or founded. This means that the information that supports the occurrence of maltreatment is of greater weight or more convincing than the information that indicates that maltreatment did not occur.

1.2.15. Family Advocacy Record. A 6-part folder opened when REASONABLE SUSPICION exists that a maltreatment incident has occurred.

1.2.16. Family Advocacy Officer (FAO). A social worker, licensed for independent practice and privileged in the MTF, designated to manage, monitor, and provide staff supervision of the Family Advocacy Program at the base level.

1.2.17. Family Advocacy Outreach Program. A prevention component of the Air Force Family Advocacy Program established to function as a central focal point for family violence education and coordination and facilitation of Family Advocacy Program prevention, community collaboration and capacity building.

1.2.18. On-Base Agencies. Any facility or service available on-base to assist military families, such as the Medical Treatment Facility, Chapel, Air Force Aid Society, Personal Affairs, Social Actions, Family Support Center, American Red Cross, the Child Development Center, Security Forces, and Air Force Office of Special Investigation.

1.2.19. Local Agencies. Civilian agencies located in a geographic proximity to a military installation. These include community, county, state, and federal facilities or services, other than those available on the installation.

1.2.20. Family Maltreatment Case Management Team. A multidisciplinary team approved by the Family Advocacy Committee (FAC) working at the installation level, tasked with the clinical evaluation and incident status determination of all incidents of family maltreatment reported to the FAP. The FMCMT is also responsible for the development and coordination of overall intervention strategies and treatment recommendations for substantiated incidents.

1.2.21. Central Registry. A central management information system maintained by each branch of the Service for identifying and recording information on incidents of child and spouse maltreatment. The Air Force Family Advocacy registry is located at AFMSA/SGPS, Brooks City-Base, TX.

1.2.22. Special Needs Identification and Assignment Coordination (SNIAC) Process. AF Process that identifies eligible DoD families with special medical or educational needs, assists those families in obtaining required services and verifies the availability of required services at the time of reassignment.

1.2.22.1. Special Need. A medical, psychological, or educational condition of a chronic nature, which requires the active management by a medical subspecialty, or special education personnel.

1.2.22.2. Individualized Educational Program (IEP). A plan written in coordination with the special education staff at the school used to implement the individual's educational needs. Home schooled children do not require IEPs.

1.2.23. Immediately Assessed Cases. High-risk cases requiring immediate protection and FAP services. These cases are immediately assessed by a credentialed and privileged provider and do not require consensus by the FMCMT prior to initiation or protective services.

1.2.24. Suspected Case. Case determination is pending further investigation. Essentially all cases during the assessment process are suspected. Duration for a case to be "suspected", and being assessed, shall not exceed 60 days from the date of the first referral.

Chapter 2

ASSIGNED RESPONSIBILITIES

2.1. General. This chapter describes the organizational structure of the 15 AW Family Advocacy Program (FAP) as well as the assigned responsibilities of the 15 AW/CC, Family Advocacy Committee (FAC), Family Maltreatment Case Management Team (FMCMT), Child Sexual Maltreatment Response Team (CSMRT), High Risk for Violence Response Team (HRVRT) and the Special Needs Identification and Assignment Coordination (SNIAC) Process.

2.2. Wing Commander (15 AW/CC) Responsibilities. The wing commander is responsible for implementation and management of the 15 AW FAP and establishing the FAC. The FAC is comprised of the Installation Wing Commander or designee (15 AW/CC), Military Treatment Facility (MTF) Commander or Deputy MTF Commander (15 MDG/CC), Family Advocacy Officer (15 MDOS/SGOH), Family Advocacy Outreach Manager (FAOM), Family Support Center Director (15 MSS/DPF), Staff Judge Advocate or designee (15 AW/JA), Chief or Deputy Chief of Personnel (15 MSS/DPC), 15th Security Forces Squadron Commander or designee (15 SFS/CC), 15th Services Squadron Commander (15 SVS/SVY-Services Youth), 15th Mission Support Squadron Commander (15 MSS/CC), Air Force Office of Special Investigation Detachment Commander or designee (AFOSI Det 601), Installation Staff Chaplain (15 AW/HC), Senior Enlisted Advisor (15 AW/CCC).

2.2.1. Appoints the 15 MDG Commander (15 MDG/CC) to administer and monitor the installation FAP.

2.2.2. Ensures an installation Family Advocacy Committee (FAC) is chaired by the MTF Commander or Deputy Commander.

2.2.3. Serves as a member of the FAC or delegates this responsibility to the Vice Wing Commander (15 AW/CV).

2.2.4. Ensures the Special Needs Coordinator (SNC) has information about all family members with special medical or educational needs. Also ensures all incidents of suspected family maltreatment are reported to the FAO and to AFOSI (including requirements in AFI 71-101, Criminal Investigations).

2.2.5. Coordinates with local social service authorities by adopting a formal written memorandum of understanding (MOU) describing procedures for reciprocal reporting of maltreatment allegations. The MOU also outlines procedures for placing victims of family maltreatment in protective custody.

2.2.6. Periodically reviews with the Staff Judge Advocate, the 15 MDG/CC, and the FAO the policy for resolving conflicts between the prosecution and clinical treatment objectives in family maltreatment cases.

2.2.7. Develops procedures to ensure immediate protective care for victims of family maltreatment.

2.3. Family Advocacy Committee (FAC) Responsibilities: (Chairperson is the 15 MDG/CC or Deputy 15 MDG/CC).

2.3.1. The FAC, in cooperation with the installation commander, ensures the implementation of the AF Standards as set forth in AFI 40-301, in elements 1.5.3.1.-1.5.3.16.

2.3.2. The FAC will meet at least quarterly to establish oversight of the installation FAP.

2.4. Management Teams.

2.4.1. Family Maltreatment Case Management Team (FMCMT): This is a multidisciplinary team that manages assessment and interventions with families referred for allegations of maltreatment. It is chaired by the FAO is implemented in accordance with Family Advocacy Program Standard M-1.

2.4.2. Child Sexual Maltreatment Response Team (CSMRT): This is a multidisciplinary team that plans investigations of suspected sexual maltreatment, simultaneously minimizing the number of interviews children undergo while effectively gathering pertinent information. It is chaired by the FAO is implemented in accordance with Family Advocacy Program Standard M-2.

2.4.3. High Risk For Violence Response Team (HRVRT): This is a multidisciplinary team that manages response to potentially dangerous situations involving FAP clients and /or staff. It is chaired by the FAO is implemented in accordance with Family Advocacy Program Standard M-3.

2.5. Special Needs Coordinator (SNC) Responsibilities. Coordinator of this

process is a 15 MDG Officer appointed by the 15 MDG/CC. The SNC process identifies eligible DoD families with special medical or educational needs, helps those families to obtain required services, and ensures families have access to necessary services if reassigned.

2.5.1. Provides case management to families accessing Special Education Services (SES), Medically Related Services (MRS), and General Medical Services (GMS).

2.5.2. Assists with locating educational programs to reduce handicapping conditions and associated medical and educational needs.

2.5.3. Develops liaison with agencies, services and medical specialists to provide early identification and referral.

2.5.4. Ensures that Special Needs referrals receive evaluation.

2.5.5. Opens Special Needs Identification and Assignment Coordination (SNIAC) Files and initiates Assignment Limitation Code ‘Q’ action after identifying special needs. Provides the member with a copy of AF Form 2523, SNIAC Information Form, as an informational statement and to clarify services provided to military families. Has member provide information to complete Q-base (Special Needs Database)**,** to enhance case management and track the assistance given to the family.

2.5.6. Provides input to the development of programs to meet the needs of families receiving SNIAC services.

2.5.7. Works in conjunction with Primary Care, Pediatric, and Flight Medicine clinics and sponsors collecting medical, dental, and educational diagnostic and prognostic statements required for reassignments, deferments, and other SNIAC actions as outlined in AFI 36-2110, Assignments.

2.5.8. Encourages sponsors to keep educational and MRS documentation current in personnel, medical, and educational records.

2.5.9. Provides education to wing populace about the SNIAC process.

2.5.10. Reviews SNIAC reports to make sure they adhere to FAP Standards.

2.5.11. Informs parents of children with special medical and educational needs about available financial assistance. Identifies trends and at-risk groups requiring prevention services.

2.5.12. Helps identify local agencies that can furnish special needs services.

2.5.13. In conjunction with the Family Member Relocation Clearance Coordinator, responds within 10 duty days to dependent relocation, reassignment, and deferment requests by providing information about the availability of local services.

2.5.14. Ensures prompt processing of AF Form 1466, Request for Family Member's Medical and Education Clearance for Travel, DD Form 2792, Medical Summary and AF Form 1466A, Request for Family Member Educational Information.

2.5.15. Coordinates overseas assignments for DoD civilian employees who have special needs family members.

Chapter 3

FAMILY MALTREATMENT REPORTING PROCEDURES

3.1. General. All agencies, departments, or individuals affiliated with the 15 AW will report all identified incidents of suspected or established family maltreatment directly to the Family Advocacy Program or local law enforcement agencies. The FAP will accept all reports of child or spouse maltreatment and ensure that appropriate agencies are expeditiously notified. In cases of child maltreatment the identifying agency or individual will notify Child Protective Services (CPS). The FAO will develop reporting procedures for the 15 MDG, 15 SFS, AFOSI, commanders & first sergeants, 15 SVS (Child Development Center, Family Day Care, and Youth Center) and the 15 MSS/DPF (Family Services). Failure to report family maltreatment can result in disciplinary actions. Exception to mandatory reporting includes chaplains receiving information through a "penitent-clergy man" relationship or confidential communications in the course of their official chaplain duties, or Judge Advocates receiving information from an established attorney-client relationship. Without an express consent to disclose they are not required to report this information.

3.1.1. The 15 AW/CC defines the Hickam AFB child supervision policy as follows:

3.1.2. Ages birth to 5: All children 5 years old and younger will have direct supervision while on government property. The supervising individual may be a helper or sibling, age 10 or older, as long as the parent or baby-sitter is nearby (meaning in the quarters or in the yard assigned to the quarters) and available to assist in the event of any emergency. A baby-sitter, age 12 or older, may be left alone with a child ages 0-5 for periods not to exceed 8 hours. Overnight baby-sitting should only be provided by persons with access to transportation and the ability to respond appropriately to emergent situations.

3.1.3. Ages 6 to 9: Dependent children may play in the area of their quarters as long as the parents provide overview supervision; i.e., once every hour. These children should have the capacity to know their address and phone number. Children 8-10 may be left in government quarters alone, but must be checked on hourly, at a minimum, by a parent or baby-sitter. Children under the age of 10 years old will not be left unattended in a vehicle. Children 6 – 10 may walk to and from school unattended with parental discretion. Children 6 - 7 may ride their bike to and from school with adult supervision. Children 8 and older may ride their bikes to and from school on their own.

3.1.4. Ages 10 to 15: Depending on age, children 10 – 15, shall be provided general supervision and have no restrictions on whereabouts, as long as the parents are aware of their whereabouts. The child must be able to utilize emergency procedures. The child must also have a general idea of the parents' whereabouts. Dependents 10 – 11 may not be left alone in the homes for periods of more than 5 hours at a time. Dependents 12 – 15 may not be left alone in the homes for periods of more than 10 hours at a time. Leaving a child of this age over 10 hours requires supervision by a baby-sitter over the age of 16. Children 10 – 15 may be left alone in a vehicle with windows open if keys are removed and handbrake set.

3.1.5. Children under the age of 18 years will not be in a public place or a private place held open to the public after 2200 and before 0600 without being accompanied by either a parent or an adult duly authorized by the parent to supervise the child. Children returning home from work or an off-base destination after 2200 must proceed directly to their residence. Children 16 – 18, may remain at home alone while parent is TDY if an adult with designated power of attorney is checking on that child daily. The period of the TDY will not exceed 5 days.

3.1.6. Children under the age of 18 years are not allowed in or around the dormitory area without direct parental supervision.

3.1.7. A parent becomes negligent when he/she fails to provide a child's basic right to necessities; i.e., food, clothing, shelter, medical, and proper supervision. Parents who fail to comply may be required to vacate their on-base quarters.

3.2. 15th Medical Group (15 MDG) Reporting Procedures.

3.2.1. If spouse/child maltreatment in the form of physical, emotional, sexual abuse, or neglect is suspected, the attending physician will examine the child to assist in determining if abuse has occurred and for medical treatment of the patient. If sexual maltreatment is suspected, the attending physician will have victim transferred to a qualified medical facility such as Tripler Army Medical Center (TAMC) emergency room or Kapiolani Sexual Abuse Treatment Center for further examination.

3.2.2. Ensure the alleged victim is medically stable, with immediate referral to a qualified medical facility should the injury be severe or life threatening. After duty hours, routine cases are transported to a qualified medical facility for assessment and evaluation.

3.2.3. Particularly in spouse maltreatment cases, be sensitive to clues of possible spouse maltreatment trauma, especially when trauma is unexplained and or inconsistent with the nature of the injury.

3.2.4. In child maltreatment, should the parent refuse to consent to child transfer for admission or further medical assessment, the attending provider will ensure contact is made with the 15 MDG/CC, Family Advocacy Officer, Staff Judge Advocate, and CPS.

3.2.5. If the attending physician or provider considers a child to be in imminent danger of health or life, or if the facts of the case warrant further medical observation, the child may be transferred to a qualified medical facility with the legal guardian's consent. Should the legal guardian refuse consent, the child will be taken into protective custody by CPS, in conjunction with civilian or military law enforcement personnel, and transferred to a qualified medical facility or placed outside the home.

3.2.6. If the victim's medical condition warrants, or if the victim is to be transferred to a qualified medical facility, the pediatrician on call will be contacted.

3.2.7. In all cases the attending physician will forward a written report of the incident, and documentation of injuries and treatment, to the FAO on the same duty day.

3.2.8. 15 MDG personnel in all departments will notify the FAP of all cases that come to their attention in which child maltreatment or neglect and spouse maltreatment is suspected. Appropriate action will be taken to initiate clinical interviews, secure appropriate safety or treatment for the maltreated victim and alleged perpetrator, and accomplish required reports.

3.2.9. 15 MDG personnel will be trained annually by FAP staff in identification and intervention of child and spouse maltreatment.

3.3. 15th Security Forces Squadron (15 SFS) Reporting Procedures.

3.3.1. 15 SFS officers responding to reported incidents of family maltreatment will secure the safety of the alleged victim.

3.3.2. 15 SFS officers responding to reported incidents of family maltreatment are encouraged on an "as-needed basis" to telephonically consult with the Family Advocacy Program Manager, or on-call Life Skills provider when dealing with family maltreatment cases.

3.3.3. If a child needs to be removed from his or her on-base residence for a medical examination, or is judged to be in imminent danger of health or life, or the parent is judged to be unsuitable to provide adequate care and supervision, the desk sergeant will consult with the FAO, or on-call provider, concerning 15 SFS transport of the child with legal parent(s) or guardian consent. Should the parent refuse consent, 15 SFS will notify Honolulu Police Department (HPD) who will work in cooperation with CPS in the lawful removal of the child/(ren) from the home. This will only be done after discussion and assessment of the situation with the FAO, or Life Skills on-call provider. Any removal of the child against parental or legal guardian consent will be accomplished in this manner. If SFS has arrived at the residence of the alleged victim, they are to remain at the residence until HPD and CPS have arrived and removed the child. Otherwise, CPS will meet 15 SFS at the Law Enforcement (LE) desk and proceed together to the residence. 15 SFS will ensure 15 AW/JA has been notified. All actions to remove a child must be in coordination with 15 AW/JA and FAO. If medical assistance is required, the child will be transported, under SFS, escort, to the 15 MDG for examination and care, during normal duty hours. After hours the child/(ren) will be transported to a qualified medical facility for examination. 15 SFS personnel will only be relieved from responsibility in this case when deemed appropriate by the desk sergeant. The alleged victim's sponsor's unit commander or first sergeant should be notified and respond.

3.3.4. 15 SFS is charged with the responsibility of aiding child victims of physical neglect. An AF Form 3545**,** Incident Report, is required on all claims of assault or neglect. All factors, such as age of child, length of time child is left unattended, whether the caretaker was within reasonable proximity, the intent of the caretaker to remain within reasonable proximity, the intent of the caretaker to provide care and initiate a response to locate the child, and condition of the caretaker, i.e., age, asleep, toxicity, etc., will all be taken into consideration on each case. 15 SFS is encouraged to consult with the FAO or AFOSI Det 601 on any questionable suspected child neglect or failure to control dependent case.

3.3.5. If photographs of the child or spouse are required, 15 SFS will notify the base to alert a photographer at the attending medical provider's request.

3.3.6. If removal of an active duty perpetrator from base housing is necessary to ensure the continued safety of the alleged victim at home, the LE Desk Sergeant will contact the squadron commander or first sergeant with the request.

3.3.7. In after-hours cases, 15 SFS may contact local ambulance services to coordinate transport of an injured victim to a qualified medical facility.

3.3.8. Security Police Reports and Analysis Section will ensure a copy of the incident report is sent as soon as possible to the FAO for inclusion in the FAP record.

3.4. Air Force Office of Special Investigation Detachment 601 (AFOSI Det 601) Reporting Procedures.

3.4.1. The FAP liaison AFOSI Det 601 agent will notify the FAO of all cases involving suspected or established family maltreatment that come to the attention of the installation AFOSI office. In turn, the FAO will notify the AFOSI Det 601 duty agent as soon as possible upon receipt of information concerning cases of physical or sexual maltreatment.

3.4.2. AFOSI Det 601 personnel will notify the FAO when a Defense Clearance and Investigation Index (DCII) check reveals information regarding previous incidents or pertinent information involving the family in question. AFOSI Det 601 personnel will index moderate to severe cases of abuse into the DCII.

3.4.3. The AFOSI Det 303 Regional Forensic Science Consultant, Travis AFB, CA will provide training upon request for medical personnel and childcare center personnel to assist them in spotting injuries consistent with child abuse. Request for training should be made in writing to AFOSI Det 601 Commander.

3.5. Commanders & First Sergeants Reporting and Case Management Procedures.

3.5.1. Coordinates with the Family Advocacy Program in order to ensure the safety of any victim.

3.5.2. Exercises their authority over the member to provide an initial "cooling off" period, if deemed necessary. This action includes a temporary removal (for a minimum of 24 hours) of the alleged perpetrator from their residence.

3.5.2.1. Consider issuance of Military No Contact Orders to ensure safety of all family members and coordinate with 15 SFS and 15 AW/JA.

3.5.2.2. Provide full support and credit to civilian court orders prohibiting contact between family members. Military members who are not sure of the full force and effect of such orders should consult with 15 AW/JA.

3.5.3. Reports all families suspected of spouse maltreatment and child maltreatment or neglect to the FAO and arrange for therapeutic counseling and referral assistance, as required.

3.5.4. When taking appropriate administrative action against the member, the commander should notify the FAO and 15 AW/JA in order to provide any necessary support to the individual or family members.

3.6. Child Development, Family Day Care and Youth Center (15 SVS/SVY) Reporting Procedures.

3.6.1. Each staff member will be responsible for identifying children who may have been maltreated or neglected.

3.6.2. The FAP will be responsible for training staff in child maltreatment prevention, identification, and reporting at least annually.

3.6.3. When a suspected case of child maltreatment or neglect is identified, the staff member will report as soon as possible to their respective Director.

3.6.4. These agencies will then be responsible for contacting the FAO once all basic practical measures have been taken and abuse remains suspected.

3.6.5. The worker or director of respective agency will be responsible for making a report to CPS.

3.7. Family Support Center (15 MSS/DPF) Reporting Procedures.

3.7.1. Participates in a periodic-base needs assessment, which results are discussed with the FAOM and FAO.

3.7.2. Coordinates with the FAOM to assist in supporting programs and services designed to target families and individuals at risk for maltreatment.

3.7.3. Refers families at risk to appropriate agencies for follow-up assistance.

3.8. Family Advocacy Officer (FAO) Reporting Procedures.

3.8.1. Ensures all Air Force FAP policies, procedures, and local program functions are followed.

3.8.2. Provides necessary assistance to CPS in managing cases of child maltreatment involving active duty members, or their dependents.

3.8.3. Provides consultation to 15AW/CC, 15 MDG/CC, 15 SFS/CC, and other appropriate agencies on matters pertaining to child and spouse maltreatment.

3.8.4. Ensures the immediate estimation of the degree of risk to maltreatment victims and ensures the evaluation of all reported incidents within a time commensurate with the degree of assessed risk.

3.8.5. Ensures notification to appropriate squadron commanders and/or first sergeants, AFOSI Det 601, and 15 AW/JA

3.8.6. When an allegation of maltreatment occurs in a DoD-sactioned activity, the FAO will notify Child Protective Services, SFS and OSI to conduct the investigative interview of the alleged offender(s). When a FAP record is opened, results of the investigative interview(s) will be presented to the FMCMT and maintained in the FAP record. Notification of the FMCMT findings will be made by the FAP to the employer/supervisor and to the alleged offender by their respective employer/supervisor.

3.8.7. When a death occurs and family maltreatment is suspected, the incident will be logged in and a record will be opened if the deceased member was a family member of an ADM or logged as “No Record Opened” if the deceased victim was not an eligible beneficiary.

3.8.7.1. The FAO will notify the installation and MTF commanders immediately.

3.8.7.2. The FAO will notify OSI immediately and obtain the OSI case number.

3.8.7.3. In child cases, Child Protective Services will be notified immediately.

3.8.7.4. The FAO will complete the High Interest Incident Worksheet and forward to AFSMA/SGOF. The MAJCOM Behavioral Health Consultant will also be notified. Quarterly updates will be provided until a final legal disposition is made.

WILLIAM J. CHANGOSE, Colonel, USAF
Commander, 15th Airlift Wing

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

AFI 36-2110, Assignments

AFI 40-301, Family Advocacy

AFI 71-101V1, Criminal Investigations **Attachment 1**

Family Advocacy Program Standards October 2004

Abbreviations and Acronyms

AFI—Air Force Instruction

AFMOA—Air Force Medical Operations Agency

AFOSI—Air Force Office of Special Investigations

AFPD—Air Force Policy Directive

AFSC—Air Force Specialty Code

CDC—Child Development Center

CONUS—Continental United States

CPS—Child Protection Services

CSMRT—Child Sexual Maltreatment Response Team

DBMS—Director, Base Medical Services

DCII—Defense Central Investigative Index

DoD—Department of Defense

DoDDS—Department of Defense Dependents Schools

DoDEA—Department of Defense Educational Assistance

DoDI—Department of Defense Instruction

FAC—Family Advocacy Committee

FACAT—Family Advocacy Command Assistance Team

FANS—Family Advocacy Nurse Specialist

FAO—Family Advocacy Officer

FAOM—Family Advocacy Outreach Manager

FAP—Family Advocacy Program

FAPA—Family Advocacy Program Assistant

FATM—Family Advocacy Treatment Manager

FMCMT—Family Maltreatment Case Management Team

FSC—Family Support Center

FTT—Failure to Thrive

GMS—General Medical Services–

HPD—Honolulu Police Department

HQ USAF—Headquarters, United States Air Force

HRVRT—High Risk for Violence Response Team

IEP—Individual Education Plan

LE—Law Enforcement

MAJCOM—Major Command

MAR—Morale and Recreation

MCFAPM—Major Command Family Advocacy Program Manager

MOU—Memorandum of Understanding

MPF—Military Personnel Flight

MRS—Medically Related Services

MTF—Medical Treatment Facility

OPM—Outreach Program Management

OPMT—Outreach Program Management Team

OPR—Office of Primary Responsibility

OSI—Office of Special Investigations

PCS—Permanent Change of Station

PL—Public Law

PRISM—Position Requirement Integrated Specialty Model

Q-CODE—Assignment Limitation Code Q

RCS—Report Control Symbol

SAF—Secretary of the Air Force

SES—Special Educational Services

SFS—Security Forces Squadron

SG—Surgeon General

SJA—Staff Judge Advocate

SNC—Special Needs Coordinator

SNIAC—Special Needs Identification and Assignment Coordination

TAMC—Tripler Army Medical Center

TDY—Temporary Duty Assignment

YA—Youth Activities

Attachment 2

AF FAMILY ADVOCACY PROGRAM MALTREATMENT DEFINITIONS

A2.1. Spouse Physical Abuse

A2.1.1. The non-accidental use of physical force.

A2.1.1.1. Physical force includes, but is not limited to, pushing; shoving; slapping; grabbing; poking; hair-pulling; scratching; pinching; restraining; shaking; throwing; biting; kicking; hitting with fist; hitting with a stick, strap, or other object; scalding; burning; poisoning; stabbing; applying force to throat; cutting off air supply; holding under water; using a weapon.

A2.1.2. Significant impact on the spouse involving any of the following:

A2.1.2.1. Any physical injury (including, but not limited to, pain that lasts at least four hours, bruises, cuts, sprains, broken bones, loss of consciousness);

A2.1.2.2. Reasonable potential for more than inconsequential physical injury given the degree of force used and the physical environment in which acts occurred;

A2.1.2.3. More than inconsequential fear reaction

A2.1.3. **Exclusions**

A2.1.3.1. Acts committed to protect self from imminent physical harm I: Spouse in the Act of Physical Force. All 3 of the following criteria are required:

A2.1.3.1.1. Act occurred while spouse was in the act of using physical force. “In the act” begins with the initiation of motoric behavior that typically would result in an act of physical force (for example, charging at the spouse to hit him/her) and ends when the use of force is no longer imminent.

A2.1.3.1.2. Sole function of act was to stop spouse’s use of physical force.

A2.1.3.1.3. Act used minimally sufficient force to stop spouse’s use of physical force

A2.1.3.2. Acts committed to protect self from imminent physical harm II: Threat + History of more than inconsequential physical injury. Both of the following criteria are required:

A2.1.3.2.1. Act followed spouse’s threat (verbal or nonverbal) to imminently inflict more than inconsequential physical injury.

A2.1.3.2.2. At least one previous incident of spouse inflicting more than inconsequential physical injury.

A2.1.3.3. Acts committed during physical play (including, but not limited to, horseplay, wrestling, tackle football).

A2.1.3.4. Acts committed to protect spouse or child from imminent physical harm (including, but not limited to, pushing spouse out of the way of a car, taking weapon away from suicidal spouse, stopping spouse from inflicting injury on child). Note: subsequent actions that were not directly protective (e.g., smacking spouse for even considering suicide) would not be excluded.

A2.1.4. **Sex act:** Contact between the penis and the vulva or the penis and the anus involving penetration, however slight; contact between the mouth and the penis, vulva, or anus; or

penetration of the anal or genital opening by a hand, finger, or other object.

A2.1.5. **Physically Aggressive Act:** Non-accidental act involving physical force including, but not limited to: scratching, pushing, shoving, throwing, grabbing, biting, choking, shaking,

poking, hair-pulling, slapping, punching, hitting, burning, use of a weapon (gun, knife, or other object), use of restraints, or use of one's body, size, or strength against the spouse.

A2.1.6. **Emotionally Aggressive Act:** Emotionally abusive acts include, but are not limited to:

A2.1.6.1. Berating, disparaging, humiliating victim (or other similar behavior)

A2.1.6.2. Threatening to harm victim directly or indirectly (including, but not limited to, by threatening to hurt children, pets or property)

A2.1.6.3. Harming victim's children, pets or property

A2.1.6.4. Restricting victim's access to or use of economic resources (when unwarranted)

A2.1.6.5. Isolating victim from family, friends, or social support resources

A2.1.6.6. Interfering with victim's cultural adaptation

A2.1.6.7. Stalking victim

A2.1.6.8. Obstructing victim from receiving medical services

A2.1.6.9. Trying to make victim think that s/he was crazy (or make others think that spouse is crazy)

A2.1.6.10. Interrogating victim

A2.1.7. **Psychiatric Disorders:** Symptoms meeting criteria for mental disorders as defined by the latest edition of the Diagnostic and Statistical Manual of Mental Disorders

A2.2. Spouse Sexual Abuse

NOTE: Corroboration of victim's allegations is not required to meet criteria for spouse sexual abuse.

A2.2.1. The use of physical force to compel the spouse to engage in a sex act against his or her will, whether or not the act is completed.

A2.2.2. The use of a physically or emotionally aggressive act to coerce a sex act (attempted or completed)

A2.2.3. An attempted or completed sex act involving a spouse who is unable to provide consent. That is, the victim is unable to understand the nature or conditions of the act, to decline participation, or to communicate unwillingness to engage in the sexual act (including, but not limited to, victim's illness; disability; being asleep or under the influence of alcohol or other drugs).

A2.2.4. Physical contact of a sexual nature (including, but not limited to, kissing, groping, rubbing, fondling — directly or through clothing) not meeting the above criteria but that (a) is against the expressed wishes of the spouse and (b) causes considerable distress to the spouse that lasts for more than 24 hours. "Considerable distress" involves anguish that does not necessarily meet diagnostic thresholds for psychiatric disorders but exceeds distress incurred in normal, day-to-day activities.

A2.2.5. **Unwarranted restrictions** : Warranted restrictions involve obstructing a spouse from behaviors that may injure self or others (e.g., taking a drunk spouse's car keys) or obstructing a recklessly-spending spouse from incurring debts despite an obviously grave economic situation (e.g., impending bankruptcy). Restrictions not meeting these rare circumstances would be considered unwarranted.

More than inconsequential fear reaction:

A2.2.5.1. Fear (expressed or displayed) of bodily injury to self or others

and

A2.2.5.2. At least one of the following signs of fear or anxiety lasting at least 48 hours:

A2.2.5.2.1. Persistent intrusive recollections of the incident

A2.2.5.2.2. Marked negative reactions to cues related to incident, as evidenced by (a) avoidance of cues; (b) subjective or overt distress to cues; or (c) physiological hyperarousal to cues (NOTE: Perpetrator can be a cue)

A2.2.5.2.3. Acting or feeling as if incident is recurring

A2.2.5.2.4. Marked symptoms of anxiety (any of the following):

A2.2.5.2.4.1. Difficulty falling or staying asleep

A2.2.5.2.4.2. Irritability or outbursts of anger

A2.2.5.2.4.3. Difficulty concentrating

A2.2.5.2.4.4. Hypervigilance (i.e., acting overly sensitive to sounds and sights in the environment; scanning the environment expecting danger; feeling keyed up and on edge)

A2.2.5.2.4.5. Exaggerated startle response

A2.2.6. **Threatening:** Verbal or nonverbal acts perceived by victim or witness as signifying that victim's physical integrity was at risk at the time or would be in the future.

A2.2.7. **Stress-related somatic symptoms:** Some victims show impact through physical, rather than psychological, symptoms. Stress-related somatic symptoms are physical problems that are caused by or worsened by stressful incidents. Such somatic symptoms can include, but are not limited to, aches and pains, migraine, gastrointestinal problems, or other stress-related physical ailments.

A2.2.8. **Psychiatric Disorders:** Symptoms meeting criteria for mental disorders as defined by the latest edition of the Diagnostic and Statistical Manual of Mental Disorders

A2.3. Spouse Emotional Abuse

A2.3.1. Non-accidental act or acts (excluding physical and sexual abusive acts) such as those listed below. Acts not listed, but of similar severity, are also eligible.

A2.3.1.1. Berating, disparaging, degrading, humiliating victim (or other similar behavior)

A2.3.1.2. Interrogating victim

A2.3.1.3. Restricting victim's ability to come and go freely (when unwarranted)

A2.3.1.4. Obstructing victim's access to assistance (including, but not limited to, law enforcement, legal, protective, or medical resources)

A2.3.1.5. Threatening victim (including, but not limited to, indicating/implying future physical harm, sexual assault)

A2.3.1.6. Harming, or indicating that offender will harm, people/things that victim cares about, such as children, self, other people, pets, property

A2.3.1.7. Restricting victim's access to or use of economic resources (when unwarranted)

A2.3.1.8. Restricting victim's access to or use of military services (including, but not limited to, taking away dependent's ID)

A2.3.1.9. Isolating victim from family, friends, or social support resources

A2.3.1.10. Stalking victim

A2.3.1.11. Trying to make victim think that s/he is crazy (or make others think that spouse is crazy)

A2.3.2. Significant impact on the spouse involving any of the following:

A2.3.2.1. Psychological harm, including any of the following

A2.3.2.1.1. Victim's more than inconsequential fear reaction

A2.3.2.1.2. Significant psychological distress (Major Depressive Disorder, Post-Traumatic Stress Disorder, Acute Stress Disorder, or other psychiatric disorders, at or near diagnostic thresholds) related to, or exacerbated by, the act(s)

A2.3.2.1.3. Victim's fear of emotionally abusive act(s) that significantly interfere(s) with the victim's ability to carry out any of these five major life activities: work; education; religion; necessary medical or mental health services; or contact with family/friends.

A2.3.2.2. Stress-related somatic symptoms (related to or exacerbated by the acts) that significantly interfere with normal functioning

A2.3.3. **Deprivation:**

A2.3.3.1. The withholding of, or withholding access to, adequate food, shelter, hygiene, or necessary medical/psychiatric services; or

A2.3.3.2. Gross negligence regarding the safety needs of the incapable spouse. More than inconsequential physical injury: An injury involving any of the following:

A2.3.3.2.1. Any injury to the face or head

A2.3.3.2.2. More than superficial bruise(s)

A2.3.3.2.3. More than superficial cut(s)

A2.3.3.2.4. Bleeding

A2.3.3.2.5. Welts

A2.3.3.2.6. Loss of consciousness

A2.3.3.2.7. Loss of functioning (including, but not limited to, sprains, broken bones, detached retina, loose or chipped teeth)

A2.3.3.2.8. Damage to internal organs

A2.3.3.2.9. Disfigurement (including, but not limited to, scarring)

A2.3.3.2.10. Swelling lasting at least 24 hours

A2.3.3.2.11. Pain felt (a) in the course of normal activities and (b) at least 24 hours after the physical injury was suffered.

NOTE: At times, the victim is (a) unable to report verbally about pain or (b) inaccessible for assessment. In such cases, the criterion is met if the nature of the injuries would typically result in pain as defined above.

A2.4. Spouse Neglect

A2.4.1. One spouse is incapable of self-care due to substantial limitations in one or more of the following areas:

A2.4.1.1. Physical (including, but not limited to, quadriplegia)

A2.4.1.2. Psychological/Intellectual (including, but not limited to, vegetative depression, very low IQ, psychosis)

A2.4.1.3. Cultural (including, but not limited to, inability to communicate, inability to manage activities of rudimentary daily living due to foreign culture)

A2.4.2. Deprivation-related significant impact on the incapable spouse via act(s) or omission(s). Deprivation-related significant impact involves any of the following:

A2.4.2.1. More than inconsequential physical injury resulting from capable spouse's acts or omissions

A2.4.2.2. Reasonable potential for more than inconsequential physical injury

A2.5. Child Physical Abuse

A2.5.1. The non-accidental use of physical force on the part of a child's caregiver.

A2.5.1.1. Physical force includes, but is not limited to, spanking with hand; dropping; pushing; shoving; slapping; grabbing; poking; hair-pulling; scratching; pinching; restraining; shaking; throwing; biting; kicking; hitting with fist; hitting with a stick, strap, or other object; scalding; burning; poisoning; stabbing; applying force to throat; cutting off air supply; holding under water; using a weapon.

A2.5.2. Significant impact on the child involving any of the following:

A2.5.2.1. More than inconsequential physical injury;

A2.5.2.2. Reasonable potential for more than inconsequential physical injury, given the degree of force used and the physical environment in which the acts occurred;

A2.5.2.3. More than inconsequential fear reaction.

A2.5.3. **Exclusion**

A2.5.3.1. Acts committed to protect self from imminent physical harm, as evidenced by all 3 of the following:

A2.5.3.1.1. Act occurred while child/adolescent was in the act of using physical force. "In the act" begins with the initiation of motoric behavior that typically would result in an act of physical force (for example, charging at the parent to hit him/her) and ends when the use of force is no longer imminent.

A2.5.3.1.2. Sole function of act was to stop child/adolescent's use of physical force.

A2.5.3.1.3. Act used minimally sufficient force to stop child/adolescent's use of physical force

A2.5.3.2. Acts committed during developmentally appropriate physical play (including, but not limited to, horseplay, wrestling, tackle football).

A2.5.3.3. Acts committed to protect child from imminent physical harm (including, but not limited to, grabbing child to prevent her from being hit by a car). Note: a parent's subsequent actions that were not directly protective (e.g., whipping the child with a switch for running into the street) would not be excluded.

A2.5.4. **Sexual gratification:** Providing sexual arousal or pleasure or appealing to prurient interest. Does not require overt evidence of arousal (e.g., erection, vaginal lubrication, ejaculation, orgasm)Without direct physical contact between child and offender: Non-contact exploitation involves no physical contact between offender and child. Thus, some forms involve sexual gratification from activities in which no one touches the child sexually, whereas other forms involve the offender forcing, tricking, enticing, threatening or pressuring the child to engage in direct sexual contact with someone other than the offender.

A2.5.5. **Child prostitution:** An act of engaging or offering the services of a child to a person to perform sexual acts for money or other consideration with that person or any other person.

A2.5.6. **Child pornography:** Media (e.g., visual, audio, written) containing the prurient depiction of a child engaged in explicit sexual conduct, real or simulated, or the lewd exhibition of the genitals intended for the sexual gratification of a user.

A2.6. Child Sexual Abuse

A2.6.1. Non-contact exploitation — Forcing, tricking, enticing, threatening or pressuring a child to participate in acts for anyone's sexual gratification without direct physical contact between child and offender.

A2.6.1.1. Acts include, but are not limited to, exposing child's or offender's genitals, anus, or breasts; having child masturbate or watch masturbation; having child participate in sexual activity with a third person (including child prostitution); having child pose, undress or perform in a sexual fashion (including child pornography); exposing child to pornography or live sexual performance; "peeping" or other prurient watching (i.e., voyeurism)

A2.6.2. Rape — Use of physical force, emotional manipulation, or a child's youth or naïveté to engage in penis-vulva or penis-anus penetration (of child, perpetrator, or both), however slight.

A2.6.3. Other sexual assault — Physical contact of a sexual nature between child and perpetrator not involving penis-vulva or penis-anus penetration, including, but not limited to:

A2.6.3.1. Oral-genital or oral-anal contact

A2.6.3.2. Non-penile penetration of vulva or rectum (for example, with hands, fingers, or objects)

A2.6.3.3. Attempted penetration of the vulva or rectum

A2.6.3.4. Groping, rubbing, fondling, stroking, or similar behavior — directly or through clothing

A2.6.4. **Disability:** Impairment resulting in some restriction or lack of ability to perform an action or activity in the manner or within the range considered normal.

A2.6.5. **Significant disruption:** Given child's developmental level and trajectory evident before alleged maltreatment, child's current development is substantially worse than would have been expected.

A2.6.6. **Stress-related somatic symptoms:** Some victims show impact through physical, rather than psychological, symptoms. Stress-related somatic symptoms are physical problems that are caused by or worsened by stressful incidents. Such somatic symptoms can include, but are not limited to aches and pains, migraine, gastrointestinal problems, or other stress-related physical ailments.

A2.6.7. **Psychiatric Disorders:** Symptoms meeting criteria for mental disorders as defined by the latest edition of the Diagnostic and Statistical Manual of Mental Disorders

A2.7. Child Emotional Abuse

A2.7.1. Non-accidental act or acts (excluding physical and sexual abusive acts) such as those listed below. Acts not listed, but of similar severity, are also eligible.

A2.7.1.1. Berating, disparaging, humiliating child (or other similar behavior)

A2.7.1.2. Threatening child (including, but not limited to, indicating/implying future physical harm, abandonment, sexual assault)

A2.7.1.3. Harming/abandoning — or indicating that alleged offender will harm/abandon — people/things that child cares about, such as loved ones, pets, property (including exposing child to criteria-meeting or subthreshold spouse maltreatment)

A2.7.1.4. Confining child (a means of punishment involving restriction of movement, as by tying a child's arms or legs together or binding a child to a chair, bed, or other object, or confining a child to an enclosed area [such as a closet])

A2.7.1.5. Scapegoating child

A2.7.1.6. Coercing the child to inflict pain on him/herself (including, but not limited to, ordering child to kneel on split peas for long periods)

A2.7.1.7. Disciplining child (through physical or non-physical means) excessively (i.e.,

extremely high frequency or duration, though not meeting physical abuse criteria)

A2.7.2. Significant impact on the child involving any of the following:

A2.7.2.1. Psychological harm, including either

A2.7.2.1.1. More than inconsequential fear reaction

A2.7.2.1.2. Significant psychological distress (Major Depressive Disorder, Post- Traumatic Stress Disorder, Acute Stress Disorder, or other psychiatric disorders, at or near diagnostic thresholds) related to the act(s)

A2.7.2.2. Reasonable potential for psychological harm

A2.7.2.2.1. The act (or pattern of acts) creates reasonable potential for the development of a psychiatric disorder (at or near diagnostic thresholds) related to, or exacerbated by, the act(s). The child's level of functioning and the risk and resilience factors present should be taken into consideration

A2.7.2.2.2. The act (or pattern of acts) carries a reasonable potential for significant disruption of the child's physical, psychological, cognitive, or social development

A2.7.2.3. Stress-related somatic symptoms (related to or exacerbated by the acts) that significantly interfere with normal functioning

Note that child emotional abuse includes a "significant potential for psychological harm" criterion, whereas spouse emotional abuse does not include a "potential" criterion. This is because developing children are inherently vulnerable and because psychological impact is expressed differently at different stages of development (e.g., an infant will not display symptoms of diagnosable depression, whereas a 10-year old may).

A2.7.3. **Exclusion**

Excluded are generally accepted practices such as child car seats, safety harnesses, swaddling of infants, and discipline involving "grounding" a child or restricting a child to his/her room.

A2.7.4. **Egregious:** Egregious acts or omissions show striking disregard for child's well-being. As such, they are not merely examples of inadvisable or deficient parenting, but must clearly fall below the lower bounds of normal parenting.

A2.8. Child Neglect

A2.8.1. Egregious act(s) or omission(s) on the part of the child's caregiver that deprives the child of needed age-appropriate care.

A2.8.1.1. Lack of supervision: Egregious absence or inattention. Child's age and level of functioning should be considered in making determination about level of supervision required. Note: Leaving children ten or older unattended in a vehicle for brief periods of time in a safe area DOES NOT meet this criterion.

A2.8.1.2. Exposure to physical hazards: Inattention to child's safety by exposing child to physical dangers (including, but not limited to, exposed wiring; broken glass; non-secured, loaded guns in home; illegal drugs in home; dangerous or unhygienic pets; asking child to perform dangerous activities; driving while intoxicated with child in vehicle).

A2.8.1.3. Educational neglect: Knowingly allowing the child to have extended or frequent absences from school, neglecting to enroll the child in some type of home schooling or public or private education, or preventing the child from attending school for other than justifiable reasons (when education is compulsory by law).

A2.8.1.4. Medical neglect: Refusal or failure to provide appropriate, medically indicated health care (including, but not limited to, failure to obtain appropriate medical, mental health, dental care) although the parent was financially able to do so or was offered other means to do so. It includes withholding of medically indicated treatment for a child with life threatening conditions.

A2.8.1.5. Deprivation of necessities: The failure to provide age-appropriate nourishment, shelter and clothing. Includes non-organic failure to thrive (which must be determined by a competent medical authority), a type of child neglect evidenced by an infant's or young child's failure to adequately grow and develop to or above the third percentile in height and weight when no organic basis for this deviation is found.

A2.8.1.6. Abandonment: The caregiver is absent and does not intend to return or is away from the home for more than 24 hours without having arranged for an appropriate surrogate caregiver.

A2.8.2. Significant impact on the child involving any of the following:

A2.8.2.1. More than inconsequential physical injury;

A2.8.2.2. Psychological harm, including either

A2.8.2.2.1. Child's more than inconsequential fear reaction; or

A2.8.2.2.2. Significant psychological distress (Major Depressive Disorder, Post-Traumatic Stress Disorder, Acute Stress Disorder, or other psychiatric disorders, at or near diagnostic thresholds) related to, or exacerbated by, the act(s) or omission(s)

A2.8.3. Stress-related somatic symptoms (related to or exacerbated by the acts) that that significantly interfere with normal functioning.

A2.8.4. Reasonable potential for more than inconsequential physical injury given the act(s)/omission(s) and child's physical environment

A2.8.5. Reasonable potential for psychological harm

A2.8.5.1. The act/omission (or pattern of acts/omissions) creates reasonable potential for the development of a psychiatric disorder (at or near diagnostic thresholds). The child's level of functioning and the risk and resilience factors present should be taken into consideration.

A2.8.5.2. The act (or pattern of acts) creates a reasonable potential for significant disruption of the child's physical, psychological, cognitive, or social development