BY ORDER OF THE COMMANDER,
15TH AIR BASE WING

15 ABW INSTRUCTION 40-301

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Medical Command

FAMILY ADVOCACY PROGRAM

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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

This document is substantially revised and must be completely reviewed.

Chapter 1

GENERAL

1.1. Concept of Operation. Family Advocacy support to the 15th Air Base Wing and units assigned, attached, or associated with the 15 ABW 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 ABW 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 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 base organizational units and active duty members, Air Reserve Components and Air National Guard units.

1.2. Definition of Terms.

1.2.1. Child. The term "child" means a biological child, adopted child, stepchild, foster child, or ward. The child must also be under the age of 18 and is eligible for services 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 also includes an individual of any age who is incapable of self-support because of a mental or physical incapacity and for whom care in a military medical treatment program is authorized.

1.2.2. Spouse. An individual who is married and either (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. Victim. An individual who is the subject of maltreatment.

1.2.4. Offender. Any person who causes the maltreatment of a child, while in a caretaker role, or the maltreatment of their spouse, or whose act, or failure to act, substantially impaired the heath 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.

1.2.5. Extrafamilial Caregiver. This category is for extrafamilial caregivers where there are allegations of major physical injury, death due to maltreatment, or child sexual abuse and the caregiver was not in a DoD sanctioned role or activity. Also included are extrafamilial offenders where there are allegations of child sexual abuse, the offender was 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, or civilians. When there are allegations of minor physical injury, emotional maltreatment, and neglect where there is no serious injury, alleged victims and their families may receive services, but no record would be activated and no information about the incident would be reported to Air Force Medical Operations Agency (AFMOA) Family Advocacy Division, Brooks Air Force Base, Texas.

1.2.6. Child Maltreatment. The physical injury, sexual maltreatment, emotional maltreatment, deprivation of necessities, or other maltreatment of a child under the age of 18 years or an individual of any age who is incapable of self-support due to a mental or physical incapacity. The term encompasses acts and omissions on the part of a person responsible for the child's welfare; i.e., parent, guardian, employee of a residential facility, or any person providing out-of-home care. The definition also includes incidents of child-to-child sexual maltreatment when the alleged offender is in a position of power over the victim.

1.2.7. Child Physical Maltreatment. Physical acts against a child that caused major or minor physical injury to the victim. Major injuries or acts include brain damage or skull fracture, subdural hemorrhage or hematoma, bone fracture, shaking or twisting of infants and young children, dislocations or sprains, internal injuries, poisoning, burns or scalds, severe cuts, lacerations, bruises or welts; or other physical injury that seriously impairs the health or physical well-being of the child victim. Minor injuries or acts include minor cuts, bruises or welts; other shaking or twisting incidents that do not result in significant injury. An injury does not have to be visible for physical maltreatment to be present.

1.2.8. Child Emotional Maltreatment. Maltreatment includes intentional berating, disparaging or other verbally abusive behavior toward the child, and violent acts that may not cause observable injury. An emotionally maltreated child manifests low self-esteem, chronic fear or anxiety, conduct disorders, affective disorders, or other cognitive or mental impairment. Acts or pattern of acts, omissions or a pattern of omissions, or passive or passive-aggressive inattention to a child's emotional needs, resulting in an adverse affect upon the child's psychological well being.

1.2.9. Child Physical Neglect. A type of child abuse or maltreatment whereby a child is deprived of needed age-appropriate care by act or omission of the child's parent, guardian, caregiver, employee of a residential facility, or staff person providing out-of-home care under circumstances indicating that the child's welfare is harmed or threatened. Child neglect includes "Deprivation of Necessities," "Non-Organic Failure to Thrive," "Lack of Supervision," "Educational Neglect," "Abandonment," or "Medical Neglect."

1.2.9.1. Deprivation of Necessities: Failure to provide appropriate nourishment, appropriate shelter, and clothing.

1.2.9.2. Non-Organic Failure to Thrive: A type of child neglect which manifests itself in an infant's or young child's failure to adequately grow and develop when no organic basis for this deviation is found. Usually such children register below the third percentile in height and weight.

1.2.9.3. Lack of Supervision: Characterized by the absence or inattention of the parent, guardian, foster parent or other caretaker that results in injury to the child being unable to care for himself or herself, or an injury or serious threat of injury to another person because the child's behavior was not properly monitored.

1.2.9.4. Educational Neglect: Knowingly allowing a child to have extended or frequent absences from school, neglecting to enroll a child in school, or preventing a child from attending school for other than justified reasons.

1.2.9.5. Abandonment: The caregiver is absent and does not intend to return or is away from home for an extended period of time without having arranged for an appropriate surrogate caregiver.

1.2.9.6. Medical Neglect: The 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.

1.2.10. Child Sexual Maltreatment. The employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or having a child assist any other person to engage in, any sexually explicit conduct (or any simulation of such conduct), or the rape, molestation, prostitution, or other such forms of sexual exploitation of children, or incest with children. All sexual activity between an offender and a child, when the offender is in a position of power over the child, is considered sexual maltreatment. Sexual maltreatment specifically includes the following:

1.2.10.1. Exploitation: The victim is made to participate in the sexual gratification of another person without direct physical contact between them. Exploitation includes forcing or encouraging a child to do any of the following: expose the child's genitals or (if female) breasts, to look at another individual's genitals or (if female) breasts, to observe another's masturbatory activities, to view pornographic photographs or read pornographic literature, to hear sexually explicit speech, or to participate in sexual activity with another person, such as in pornography or prostitution, in which the alleged offender does not have direct physical contact with the child.

1.2.10.2. Rape/Intercourse: Sexual intercourse between an offender, male or female, and a child, male or female, that involves the penetration of the child's vagina, labia, or rectum, however slight, by means of physical force. The penetration may result from emotionally manipulating the child or by taking advantage of a child's naiveté rather than physical force.

1.2.10.3. Molestation: Fondling or stroking of breasts or genitals, oral sex, or attempted penetration of the child's vagina, labia, or rectum.

1.2.10.4. Other Sexual Maltreatment: All other types of child sexual abuse or maltreatment not mentioned above.

1.2.11. 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: Child Development Center's, DoD Educational Assistance schools, buses, recreation facilities, Licensed Home Day Care Facilities, DoD sponsored Boy or Girl Scout functions, or locations where Red Cross trained baby-sitting occurs.

1.2.12. Spouse Emotional Maltreatment. Acts or threats that adversely affect the psychological well being of a spouse, including those intended to intimidate, coerce, or terrorize the spouse. Such acts and threats include those likely to result in physical injury, property damage or loss, or economic injury. Arguments alone are not sufficient to substantiate emotional maltreatment.

1.2.12.1. Property violence: Property damage that occurs as a means to scare or intimidate. It includes, but is not limited to the breaking of property, putting a fist or foot through a wall or door, throwing food, breaking dishes, and damaging automobiles. Injury of pets is included in this category.

1.2.12.2. Psychological violence: Explicit or implicit threats of violence, extreme controlling types of behavior, extreme jealousy, mental degradation (name calling, etc.) and isolating behavior.

1.2.13. Spouse Physical Maltreatment. Use of physical force that causes physical injury to the spouse. Violence is generally used to intimidate, control, or force a spouse to do something against his or her will. This may include grabbing, pushing, holding, slapping, choking, punching, sitting or standing on, kicking, hitting with objects, and assaults with knives, firearms or other weapons.

1.2.14. Spouse Sexual Maltreatment. The use of physical violence, intimidation, or the explicit or implicit threat of future violence by a spouse to coerce the other spouse to engage in any sexual activity. Sexual intercourse between an alleged offender and a spouse that involves the penetration of the vagina or rectum, however slight, by means of physical force. Sexual abuse of a spouse specifically includes "Rape or Intercourse." It also includes coercing the spouse to participate in sexual activity with another person, as in pornography or prostitution.

1.2.15. Maltreatment Case Status. The status of the case from the initial report through the time of the final case status determination by the Family Maltreatment Case Management Team (FMCMT). There are three status determinations:

1.2.15.1. Unsubstantiated - Did Not Occur: A case that has been assessed and the FMCMT determines the available information supports the claim that maltreatment did not occur.

1.2.15.2. Unsubstantiated – Unresolved: A case that has been assessed and the FMCMT determines the available information is insufficient to support the maltreatment allegations.

1.2.15.3. Substantiated: A case that has been assessed and the FMCMT determines the preponderance of available information indicates that maltreatment has occurred. 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.

1.2.16. Family Advocacy Record. A separate case record established for each family referred for exceptional medical or educational needs or suspected maltreatment. The Family Advocacy Officer at each Air Force medical treatment facility maintains these records.

1.2.17. Family Advocacy Officer (FAO). A credentialed and privileged social worker designated to manage, monitor, and provide staff supervision of the Family Advocacy Program at the base level.

1.2.18. Family Advocacy Outreach Manager (FAOM). A civilian Clinical Social Worker with a master's degree from an accredited School of Social Work providing outreach social services within the Air Force FAP. Other human service degrees are acceptable where the incumbent has extensive experience working in family maltreatment intervention programs. The FAOM provides outreach services with the FAP.

1.2.19. Outreach Programs. Proactive initiatives designed to reduce the incidence and severity of exceptional medical or educational needs and family maltreatment. These programs are directed at the general population and seek to increase awareness and develop skills.

1.2.19.1. Outreach Services. Services designed to reduce coping limitations within families with exceptional needs or families at risk for maltreatment.

1.2.20. 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 Care and Youth Center, Security Forces, and Air Force Office of Special Investigation.

1.2.21. Local Agencies. These include community, county, state, or federal facilities or services, other than the military.

1.2.22. Family Maltreatment Case Management Team. A multidisciplinary team appointed by the FAC Chairperson to participate in the case management process. The team makes incident status determinations and key case management decisions on all referrals for alleged maltreatment.

1.2.23. 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 HQ AFFMOA/SGPS, Brooks AFB, TX.

1.2.24. Exceptional Family Member Program (EFMP). AF Program that identifies eligible DoD families with exceptional medical or educational needs, assists those families in obtaining required services and verifies the availability of required services at the time of reassignment.

1.2.24.1. Exceptional Need. A medical, psychological, or educational condition of a chronic nature, which requires the active management by a medical subspecialty, or special education personnel. A general rule of thumb for determining whether a condition constitutes an "exceptional need" should include the question "Is there a need for special assignment consideration to assure availability of required medical or educational services?"

1.2.24.2. Special Education Services (SES). Those requirements outside the normal scope of 'main-stream' classes' services that are strictly educational and which include personnel with specialized training or certification.

1.2.24.3. Medically Related Services (MRS). Medical services and those services provided under professional medical supervision required by a Case Study Committee either to determine a student's eligibility for special education, if the student is eligible or, the related services required by the student. Provisions of either direct or indirect services listed in an Individualized Education Program, as necessary, for the student to benefit from the education curriculum. These services may include medical, social work, community health nursing, dietary, psychiatric diagnosis, evaluation, and follow-up, occupational therapy, physical therapy, audiology, ophthalmology, and psychological testing and therapy.

1.2.24.4. General Medical Services (GMS). Exceptional medical conditions that require active medical management by a subspecialty (not simple consultation).

1.2.24.5. Individualized Educational Program (IEP). A plan written in coordination with the special education staff at the school used to implement the individuals educational needs.

1.2.25. 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.

1.2.26. 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 ABW Family Advocacy Program (FAP) as well as the assigned responsibilities of the 15 ABW/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 Exceptional Family Member Program (EFMP).

2.2. Wing Commander (15 ABW/CC) Responsibilities. The wing commander is responsible for implementation and management of the 15 ABW FAP and establishing the FAC. The FAC is comprised of the Installation Wing Commander or designee (15 ABW/CC), Director of Base Medical Services (15 MDG/CC), Family Advocacy Officer (15 MDOS/SGOH), Family Advocacy Outreach Manager (FAOM), Family Support Center Director (15 MSS/DPF), Staff Judge Advocate (15 ABW/JA), Chief or Deputy Chief of Personnel (15 MSS/DPC), 15th Security Forces Squadron Commander (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 (AFOSI Det 601), Alcohol and Drug Abuse Prevention and Treatment Chief (15 MDOS/SGOH), Installation Staff Chaplain (15 ABW/HC).

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 15 MDG/CC.

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

2.2.4. Ensures the Exceptional Family Member Program Officer has information about all family members with exceptional 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).

2.3.1. The FAC, in cooperation with the installation commander, ensures the implementation of the AF Standards as set forth in this instruction.

2.3.2. Ensures the development of an installation directive to guide the implementation of the local FAP.

2.3.3. Reviews and approves an annual FAP plan.

2.3.4. Solicits, with the 15 ABW/CC, the required resources for implementation of the FAP.

2.3.5. Coordinates activities of individual organizations having functional responsibilities in the FAP.

2.3.6. Ensures that program evaluation conforms with the requirements of HQ AFMOA/SGPS and the DoD FAP Manager.

2.3.7. Monitors training programs for personnel having responsibilities in support of the FAP.

2.3.8. Establishes a cooperative working relationship with local community agencies.

2.3.9. Ensures written Memorandum of Understanding (MOU) exists between Hickam AFB and other agencies needed to implement the FAP, such as Child Protective Services (CPS) and the Joint Military Family Abuse Shelter. All such MOUs are developed, maintained, and periodically reviewed.

2.3.10. Establishes and selects members to the Family Maltreatment Case Management Team (FMCMT), Child Sexual Maltreatment Response Team (CSMRT), and High Risk for Violence Response Team (HRVRT).

2.3.11. Monitors the activities of the FMCMT. Reviews their policy recommendations and ensures their effectiveness.

2.3.12. Addresses unusually sensitive cases, problems or constraints identified by the FMCMT and the FAO.

2.3.13. Develops installation policies and procedures to ensure notification of appropriate agencies in incidents of suspected maltreatment.

2.3.14. Establishes written policy and procedures for local response to child sexual maltreatment via the CSMRT, and will ensure that installation personnel are trained in their roles in the response process.

2.3.15. Ensures written policies and procedures are developed for response to incidents of death due to maltreatment and episodes of child sexual maltreatment in DoD-sanctioned activities IAW Air Force and DoD guidance.

2.3.16. In cases of alleged multiple-victim child sexual maltreatment in DoD-sanctioned activities, the CSMRT and the FAC will consider recommending that the installation commander request deployment of the DoD Family Advocacy Command Assistance Team (FACAT).

2.3.17. When the FACAT is deployed, the CSMRT will serve as the nucleus for the installation level task force, provide an in brief to the FACAT concerning assessment of the allegation(s) of child sexual abuse and maintain continuous interface with the FACAT.

2.3.18. Ensures that FAP training, outreach, and community awareness education is provided, regardless of the availability of civilian FAP staff funded by HQ AFMOA/SGPS.

2.3.19. Ensures that FAP staff receive their necessary continuing education training. The FAC Chairperson will ensure that FAC members are trained at least annually on committee roles and responsibilities and overall FAP mission.

2.3.20. Meets at the call of the chairperson or at least every 3 months. The FAC will maintain minutes of meetings that reflect attendance, content of discussions and decisions made. Reference to individuals or families receiving FAP services will be by case number rather than name.

2.4. Family Maltreatment Case Management Team (FMCMT) Responsibilities. Coordinator of this team is the 15 ABW/FAO. The purpose of this management team is to identify, evaluate, recommend treatment, and prevent maltreatment of Air Force family members.

2.4.1. Meets at the call of the FAO, or at least monthly.

2.4.2. Ensures all reports of alleged maltreatment are assessed for risk level within 24 hours.

2.4.3. Establishes procedures for the unit commander to follow in offering protective services to family members.

2.4.4. Determines the status of all cases.

2.4.5. Ensures the preparation and submission of DD Form 2486**,** Child/Spouse Abuse Incident Report, RCS: DD-FM&P(W)1738 and AF Form 2528, Family Maltreatment Data, (when applicable) according to FAP Standards on all maltreatment reports.

2.4.6. Prepares and submits required DoD forms and reports.

2.4.7. Identifies family maltreatment trends, using available data on families. Also identifies at-risk groups requiring prevention services.

2.4.8. Reviews all open family maltreatment cases at least once every 3 months to ensure that the case management plan is current. Also reviews substantiated sexual abuse cases monthly.

2.4.9. Establishes procedures for hospitalizing victims of family maltreatment when no alternatives are available.

2.4.10. Recommends to the squadron commander reassignment of the abuser when required treatment services are not available in the local area.

2.4.11. Reports child or spouse deaths due to maltreatment. Ensures accurate and timely (24 hour) reporting to HQ AFMOA/SGPS and the PACAF/SG.

2.4.12. Refers issues and recommendations to the FAC when the FMCMT cannot resolve them, or for required actions beyond the authority of the FMCMT.

2.5. Child Sexual Maltreatment Response Team (CSMRT) Responsibilities. Coordinator of this team is the 15 ABW/FAO. The team consists of the FAO, an AFOSI agent, a JA representative, a Child Development Specialist, and optional representatives from other agencies that have child protection responsibilities. This multidisciplinary team plans investigations of suspected abuse, simultaneously minimizing the number of interviews children undergo while effectively gathering pertinent information. CSMRT members can also be members of the FMCMT. The CSMRT takes coordinated action within 72 hours of any report of child sexual abuse, without waiting for a scheduled meeting. The CSMRT follows published guidelines, including FAP Standards.

2.5.1. Meets at the call of the chairperson.

2.5.2. Ensures special efforts to protect the alleged victims and to preserve evidence of a possible crime.

2.5.3. Ensures that the child undergoes as few interviews as possible.

2.5.4. Utilizes the Children’s Justice Center for interviewing whenever possible.

2.5.5. Monitors the child's safety.

2.5.6. Orders medical examinations of the victim when recommended by medical, legal, or investigative personnel.

2.5.7. Prescribes and refers child sexual abuse offenders, who are on active duty, to appropriate treatment programs.

2.5.8. Ensures compliance with AFI 51-201 Administration of Military Justice, Chapter 7, Victim and Witness Program, and the Victim Witness Protection Act of 1982 requirements.

2.6. Exceptional Family Member Program (EFMP) Officer Responsibilities. Coordinator of this program is the 15 ABW/EFMP Officer, or the 15 ABW/FAO. The EFMP identifies eligible DoD families with exceptional medical or educational needs, helps those families to obtain required services, and ensures families have access to necessary services if reassigned.

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

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

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

2.6.4. Ensures that EFMP referrals receive evaluation.

2.6.5. Opens EFMP cases and initiates Assignment Limitation Code 'Q' action after identifying exceptional needs. Provides the EFMP member with a copy of AF Form 2523, Exceptional Family Member Program, as an informational statement and to clarify services provided to military families. Has member complete AF Form 2525, Exceptional Family Member Program Cover Sheet**,** to enhance case management and to track the assistance given to the family.

2.6.6. Develops service plans when requested by the family. Uses AF Form 2522, Family Advocacy Program Intake**,** to collect demographic data on all family members.

2.6.7. Provides input to the development of programs to meet the needs of families receiving EFMP services.

2.6.8. 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 EFMP actions as outlined in AFI 36-2110, Assignments.

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

2.6.10. Provides education to wing populace about the EFMP.

2.6.11. Reviews EFMP reports to make sure they adhere to FAP Standards.

2.6.12. Informs parents of children with special medical and educational needs about available financial assistance.

2.6.13. Identifies trends and at-risk groups requiring prevention services.

2.6.14. Helps identify local agencies that can furnish EFMP services.

2.6.15. Responds within 10 duty days to dependent relocation, reassignment, and deferment requests by providing information about the availability of local services.

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

2.6.17. Coordinates overseas assignments for DoD civilian employees who have exceptional family members.

Chapter 3

FAMILY MALTREATMENT REPORTING PROCEDURES

3.1. General. All agencies, departments, or individuals affiliated with the 15 ABW will report all identified incidents of suspected or established family maltreatment directly to the FAO. The FAO will accept all reports of child abuse maltreatment and ensure that appropriate agencies are expeditiously notified. In cases of child maltreatment the identifying agency or individual will notify 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).

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

3.2.1. If spouse/child maltreatment in the form of physical or sexual abuse 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, attending physician will have victim transferred to Tripler Army Medical Center (TAMC) for further examination.

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

3.2.3. Particularly in spouse abuse cases, be sensitive to clues of possible spouse abuse trauma, especially when trauma is unexplained and 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 Honolulu Child Protective Services.

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 TAMC with the legal guardian's consent. Should the legal guardian refuse consent, the child will be taken into protective custody by Child Protection Services, in conjunction with civilian or military law enforcement personnel, and transferred to TAMC or placed outside the home.

3.2.6. If the victim's medical condition warrants, or if the victim is to be transferred to TAMC, 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 abused 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 when dealing with family maltreatment cases.

3.3.3. If a child needs to be removed from their 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 Child Protective Services (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 ABW/JA has been notified. All actions to remove a child must be in coordination with 15 ABW/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 TAMC emergency room 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.

3.3.4.1. The 15 ABW/CC defines the Hickam AFB child supervision policy as follows:

3.3.4.1.1. 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.

3.3.4.1.2. 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 under the age of 10 require a baby-sitter or parent at the residence at all times. Children under the age of 10 years old, will not be left alone in government quarters nor will they be left unattended in a vehicle. Children 6 – 10 may walk to school unattended with parental discretion. Children 6 - 7 may ride their bike to school with adult supervision. Children 8 and older may ride their bikes to school on their own.

3.3.4.1.3. 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.

3.3.4.1.4. Children under the age of 16 years will not be in a public place or a private place held open to the public after 2200 and before 0400 without being accompanied by either a parent or an adult duly authorized by the parent to supervise the child. 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.

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

3.3.5. A parent becomes negligent when he/she fail 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. Three or more incidents of non-compliance constitute reason to consider quarter vacation action.

3.3.6. 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.

3.3.7. 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.

3.3.8. In maltreatment cases, 15 SFS will contact the active duty member's commander or first sergeant. The FAO, or on call Life Skills Flight provider, will also be contacted to ensure timely follow-up on each case.

3.3.9. In after-hours cases, 15 SFS may contact 15 MDG ambulance services to coordinate transport of an injured victim to TAMC.

3.3.10. 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 FAO 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.

3.5.3. 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 ABW/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 abused 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. Performs 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 Honolulu Child Protective Services in managing cases of child abuse involving active duty members, or their dependents.

3.8.3. Provides consultation to 15 SFS/CC, 15 MDG/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. Provides initial formalized case identification assessments and treatment plans of child and spouse maltreatment victims and offender families.

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

3.8.7. Establishes procedures for necessary referral of FAP clientele to appropriate military and civilian resources.

3.8.8. Acts as chairperson of the FMCMT.

3.8.9. Ensures the composition of the FMCMT includes: FAO, Pediatrician, 15 SPS, AFOSI Det 601, FATM (s), Chaplain, 15 ABW/JA, 15 MSS/DPS and 15 SVS/SVY. An invitation may be extended to CPS to attend FMCMT meetings, at the discretion of the FAO.

3.8.10. Provides EFMP assignment and deferment assistance when needed.

3.8.11. Directly supervises the activities of the FAOM, FATM, FAPA and the Family Advocacy Nurse Specialist (FANS).

3.9. Community Agencies Reporting Procedures

3.9.1. When necessary, the FAO should notify the Honolulu CPS office of child abuse and/or neglect, and spouse abuse cases involving military members. A professional working relationship is encouraged between members of the FAP and CPS.

ALBERT F. RIGGLE, Colonel, USAF
Commander, 15th Air Base 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**

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

DoDDS—Department of Defense Dependents Schools

DoDEA——Department of Defense Educational Assistance

DoDI—Department of Defense Instruction

EFMP—Exceptional Family Member Program

EMPO—Exceptional Family Member Program Officer

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

GMS—General Medical Services–

HQ USAF—Headquarters, United States Air Force

HRVRT—High Risk for Violence Response Team

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

SAS—Special Educational Services

SFS—Security Forces Squadron

SG—Surgeon General

SJA—Staff Judge Advocate

TAMC—Tripler Army Medical Center

YA—Youth Activities