Child Abuse Mandatory Reporter Training in Iowa
Abuse Identification and Reporting

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This course refers substantially to information on child abuse as developed by the Iowa Department of Human Services and to relevant Iowa law and codes.

LEARNING OUTCOME AND OBJECTIVES: Upon completion of this course, you will have the current, evidence-based information and tools you need to accurately identify and report child abuse, maltreatment, and neglect in the state of Iowa. Specific learning objectives include:

- Define child abuse as described in the Iowa Code 232.68(2).
- Explain the causes and risk factors contributing to child abuse.
- Recognize physical, psychological, behavioral, and environmental indicators of child abuse.
- Differentiate situations in which mandatory reporters must report suspected cases of abuse and maltreatment.
- Explain the requirements and procedures for reporting suspected cases of abuse.
- Identify the classifications of child abuse reporters according to the Iowa Code.
- Describe the confidentiality and immunity provisions for mandatory reporters, as well as penalties for failure to report, according to the Iowa Code.
- Describe the assessment protocol utilized by the Department of Human Services following a receipt of a report.
INTRODUCTION

Healthcare professionals have a responsibility to recognize and report suspected child abuse and maltreatment. They are often in a unique position to observe both a child’s condition and interactions with family and other caregivers. In this way, healthcare providers can support the government’s responsibility to protect children when parents or other caregivers fail to provide proper care and to intervene in cases of child maltreatment.

The first organization established with the purpose of protecting children from abuse and neglect was a nongovernmental agency; in 1874, the Society for the Prevention of Cruelty to Children was established in New York. A federal Children’s Bureau was not founded until 1912, demonstrating that Congress officially acknowledged the government’s obligation to protect children from maltreatment. The Child Abuse Prevention and Treatment Act of 1974 was signed into law many years later and was the first legislative effort of the federal government to improve the response to child abuse and neglect.

Iowa’s child abuse reporting law, Iowa Code sections 232.67 through 232.75, was initially enacted in 1978 and has been amended several times since then. The intent of the law is to identify children who are victims of abuse. The law also provides for a professional assessment to determine if abuse has occurred. Accompanying the assessment are protective services designed to protect, treat, and prevent further maltreatment.

The purpose of the Iowa law is to provide the greatest possible protection to children by encouraging the reporting of suspected child abuse. The state respects the bond between parent and child. However, the state also asserts the right to intervene for the general welfare of the child when there is a clear and present danger to the child’s health, welfare, and safety. The state does not intend to interfere with reasonable parental discipline and child-rearing practices that are not injurious to the child.

According to Iowa statute, the Department of Human Services (DHS) has the responsibility to assess reports of suspected child abuse. DHS is the agency designated by law to receive reports of suspected child abuse and neglect (DHS, 2011).

WHAT IS CHILD ABUSE?

Iowa defines an abused child as any child (a person under the age of 18) who is subjected to one or more of the ten categories of child abuse as defined in Iowa Code 232.68 as a result of the acts or omissions of the person responsible for the care of the child.

These categories include:

1. Physical abuse
2. Mental injury
3. Sexual abuse
4. Denial of critical care
5. Child prostitution
6. Presence of illegal drugs in a child’s body
7. Manufacturing or possession of a dangerous substance
8. Bestiality in the presence of a child
9. Allowing access to a registered sex offender
10. Allowing access to obscene materials
   (Iowa DHS, 2011, 2017c)

DEFINITION OF CARETAKER

The person responsible for the care of the child is defined in Iowa Code 232.68 as a parent, guardian, or foster parent. The responsible party may be a relative, or any other person with whom the child resides if that person assumes care or supervision of the child, the length of time or continuity of residence notwithstanding. The responsible party can also be an employee or agent of any public or private facility providing care for a child, including an institution, hospital, healthcare facility, group home, mental health center, residential treatment center, shelter care facility, detention center, or child care facility. The responsible party can be a person providing care for a child, but with whom the child does not reside, without reference to the duration of the care.

A person who assumes responsibility for the care or supervision of a child may assume this responsibility through verbal or written agreement, or implicitly through the willing assumption of the caretaking role.

In certain circumstances, such as an overnight trip, an educator may be considered a caretaker for a child. Another child may be considered to be the caretaker for a child under certain conditions such as babysitting.


Types of Child Abuse

PHYSICAL ABUSE

Physical abuse is the most obvious form of child abuse. Physical abuse of a child includes any nonaccidental physical injury of a child that is inflicted by a parent or caretaker. Physical abuse injuries can range from superficial bruises and marks to fractures, burns, and serious internal injuries. In severe cases, the physical abuse may lead to death. The legal definition of physical abuse is “any nonaccidental physical injury, or injury which is at variance with the history given of it, suffered by a child as the result of the acts or omissions of a person responsible for the care of the child.”
Mandatory reporters should be alert to unusual or unexplained burns, bruises, or fractures. Health services personnel should be especially attentive to cases of child abuse where there are inconsistent histories between witnesses, explanations that do not fit the degree or type of injury to the child, or changes over time to the story or explanation of the injury (DHS, 2017i).

(See also “Recognizing Physical Abuse” later in this course.)

MENTAL INJURY

Mental injury is defined in Iowa Code 622.10 as any mental injury to a child’s intellectual or psychological capacity as evidenced by an observable and substantial impairment in the child’s ability to function within the child’s normal range of performance and behavior as the result of the acts or omissions of a person responsible for the care of the child, if the impairment is diagnosed and confirmed by a licensed physician or qualified mental health professional.

Examples of mental injury may include:

- **Ignoring** the child; failing to provide necessary stimulation or to respond to a child’s needs; failing to validate the child’s worth within the normal routine of the family.
- **Rejecting** the child’s values, needs, and requests for adult validation and nurturance.
- **Isolating** the child from the family and community; denying the child normal human contact.
- **Terrorizing** the child with continual verbal abuse; creating an environment in which the child experiences fear, hostility, and anxiety; preventing the child from feeling safe and secure.
- **Corrupting** the child by promoting and reinforcing destructive antisocial behavior until the child is so impaired in socio-emotional development that interaction in normal social environments is impossible.
- **Verbally assaulting** the child with continual, excessive name-calling, harsh threats, and sarcasm resulting in humiliation and loss of self-esteem to the child.
- **Over-pressuring** the child with subtle, consistent pressure to grow up quickly and achieve prematurely in the areas of academics, physical or motor skills, or social interaction, resulting in the child feeling that he or she is never quite good enough.

(Iowa DHS, 2017g)

(See also “Recognizing Physical and Emotional Neglect” later in this course.)
CASE

Ashley
Ashley is the oldest of four siblings. When she was 3 years old, her parents were told that she was “gifted.” Ashley learned to read when she was 4 and skipped first grade. Ashley’s mother was busy with the younger siblings, and although she did not ask Ashley to help care for them, Ashley was expected to take care of herself from an early age “because she was the oldest.” At the age of 7, Ashley got up early and made breakfast, which involved using the stove. She was told that she was “too old for dolls” and was expected to practice the piano or read after school.

By age 15 Ashley completed high school and immediately enrolled in college. She struggled with the academic demands, failed at social interactions with the other students, and developed an eating disorder. Unable to maintain the high grades she customarily received, Ashley became depressed in response to the over-pressuring. Her parents expressed their disappointment with her lack of achievement and punished her when she received average grades. A concerned professor referred Ashley to the school counselor, who in turn was able to support Ashley in many areas of her life.

SEXUAL ABUSE

In Iowa, sexual abuse is defined as the commission of a sexual offense with or to a child pursuant to Iowa Code 709, Iowa Code 726.2, or Iowa Code 728.12(1), subsection 1, as a result of the acts or omissions of the person responsible for the care of the child or of a person in a home with the child. Notwithstanding Iowa Code 702.5, the commission of a sexual offense includes any sexual offense with or to a person under the age of 18 years.

There are several sub-categories of sexual abuse:

- First-degree sexual abuse exists when a serious injury causes a risk of death, permanent disfigurement, or sustained impairment, including disabling mental illness.

- Second-degree sexual abuse involves the use, or the threat of the use, of a weapon to create a risk of death or serious injury; a weapon is displayed in a threatening manner; the abused person is under the age of 12; the person committing the act is helped by one or more persons; the act is committed by force against the abused person’s will.

- Third-degree sexual abuse occurs when force is used, or the abused person is not capable of giving consent because of mental incapacity or being under the influence of a substance; the abused person is 12 or 13; the abused person is 14 or 15 and there are other factors such as cohabitation or related by blood; a person of authority uses that authority to coerce the other person; there is four years or greater age difference

- Lascivious acts with a child

- Indecent exposure

- Assault with intent to commit sexual abuse
• Indecent contact with a child
• Lascivious conduct with a minor
• Incest
• Sexual exploitation by a counselor or therapist
• Sexual exploitation of a minor
• Sexual misconduct with offenders and juveniles
  (Criminal Defense Lawyer, 2017; Iowa DHS, 2017n)

DENIAL OF CRITICAL CARE

Denial of critical care is defined as the failure on the part of the person who is responsible for the care of a child to provide adequate food, shelter, clothing, or other care necessary for the child’s health and welfare when financially able to do so or when offered financial or other reasonable means to do so. Denial of critical care includes the failure to:

• Provide adequate food and nutrition to such an extent that there is danger of the child suffering injury or death
• Provide adequate shelter to such an extent that there is danger of the child suffering injury or death
• Provide adequate clothing to such an extent that there is danger of the child suffering injury or death
• Provide adequate healthcare to such an extent that there is danger of the child suffering serious injury or death
• Provide mental health care necessary to adequately treat an observable and substantial impairment in the child’s ability to function
• Meet the emotional needs of the child necessary for normal development evidenced by the presence of an observable and substantial impairment in the child’s ability to function within the normal range of performance and behavior
• Provide proper supervision of a child which a reasonable and prudent person would exercise under similar facts and circumstances, to such an extent that the failure resulted in direct harm or created a risk of harm to the child or there is danger of the child suffering injury or death
• Protect against cruel and undue confinement of a child
- Protect the child against riding in a vehicle in which the person responsible for the care of the child is driving recklessly or driving while intoxicated

- Respond to the infant’s life-threatening condition
  (Iowa DHS, 2011, 2017e)

### CASE

**Kevin, Grade 5**

Robert attends fifth grade at a public school with his childhood friend Kevin. Robert’s mother provides him with lunch money or prepares a lunch for him to bring to school. Recently, Robert began to come home from school hungry every day and told his mother that he had given his lunch or his money to Kevin. He also let Kevin borrow a jacket, and it was never returned. His mother queried him as to why he was doing this, and Robert denied any bullying behavior on Kevin’s part; he said Kevin was just really poor and hungry and cold every day. Robert’s mother contacted the school about Kevin.

The school nurse called Kevin into the office. A sensitive discussion revealed that Kevin’s mother had been arrested and was in jail. His father was unemployed and drinking heavily. The nurse contacted Child Protective Services, and Kevin was found to have been denied critical care. As a result of an investigation by the Department of Human Services, a methamphetamine lab was discovered at Kevin’s home. Kevin was evaluated for drug exposure, placed in foster care, and eventually placed with his grandparents.

### CHILD PROSTITUTION

Child prostitution is defined as the acts or omissions of a person responsible for the care of a child that allow, permit, or encourage the child to engage in acts prohibited pursuant to Iowa Code 725.1. Prostitution is defined as a person who sells or offers for sale the person’s services as a partner in a sex act, or who purchases or offers to purchase such services (Iowa State DHS, 2011, 2017d). The acts involved in commercial sexual exploitation of children include stripping, pornography, transactional sex, and prostitution.

It is important that children involved in prostitution not be treated as offenders. All too often, one sees them labeled as “child prostitutes” or “teen prostitutes” as if it were their choice. In fact, they are being subjected to a form of modern-day slavery, leaving them vulnerable to being manipulated and exploited by predators who approach them at school, malls, parks, youth shelters, and group homes (Shared Hope International, 2017).

### CHILD SEX TRAFFICKING

In 2016, child abuse laws were amended to add child sex trafficking. Iowa Code section 232.68(2)(a)(11) defines child sex trafficking as the recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a child for the purpose of commercial sexual activity. Commercial sexual activity means any sex act or sexually explicit performances for which anything of value is given, promised to, or received by any person and includes, but is not
limited to, prostitution, participation in the production of pornography, and performance in strip clubs, as defined in Iowa Code section 710A.1. It is important to note that this category of child abuse does not require caretaker status (Iowa DHS, 2016).

**PRESENCE OF ILLEGAL DRUGS**

Presence of illegal drugs is defined as occurring when an illegal drug is present in a child’s body as a direct and foreseeable consequence of the acts or omissions of the person responsible for the care of the child (Iowa DHS, 2017k).

Iowa Code 232.77 further states:

If a health practitioner discovers in a child physical or behavioral symptoms of the effect of exposure to cocaine, heroin, amphetamine, methamphetamine, or other illegal drugs or a combination or derivatives thereof, which were not prescribed by a health practitioner, or if the health practitioner has determined through examination of the natural mother of the child that the child was exposed in utero, the health practitioner may perform or cause to be performed a medically relevant test, as defined in section 232.73, on the child. The practitioner shall report any positive results of such a test on the child to the department [Child Protective Services]. The department shall begin an assessment pursuant to section 232.71B upon receipt of such a report.

“Illegal drugs” are defined as cocaine, heroin, amphetamine, methamphetamine, other illegal drugs (including marijuana), or combinations or derivatives of illegal drugs which were not prescribed by a health practitioner.

**MANUFACTURING OR POSSESSION OF A DANGEROUS SUBSTANCE**

Manufacturing or possession of a dangerous substance is defined in Iowa Code 232.2(6)(p) as occurring when the person responsible for the care of a child:

Has manufactured a dangerous substance in the presence of the child, or knowingly allows the manufacture of a dangerous substance by another person in the presence of a child, or possesses a product containing ephedrine, its salts, optical isomers, salts of optical isomers, or pseudoephedrine, its salts, optical isomers, salts of optical isomers, with the intent to use the product as a precursor or an intermediary to a dangerous substance in the presence of the child.

For the purposes of this definition, “in the presence of a child” means the manufacture or possession occurred: in the physical presence of a child, or in a child’s home, on the premises, or in a motor vehicle located on the premises, or under other circumstances in which a reasonably prudent person would know that the manufacture or possession may be seen, smelled, or heard by a child.
Iowa Code 232.2(6)(p) defines “dangerous substance” as:

Amphetamine, its salts, isomers, or salts of its isomers; methamphetamine, its salts, isomers, or salts of its isomers; or a chemical or combination of chemicals that poses a reasonable risk of causing an explosion, fire, or other danger to the life or health of people who are in the vicinity while the chemical or combination of chemicals is used or is intended to be used in any of the following: the process of manufacturing an illegal or controlled substance, as a precursor in the manufacturing of an illegal or controlled substance, or as an intermediary in the manufacturing of an illegal or controlled substance.

The Department of Human Services (DHS) must report this type of allegation to law enforcement, as this is a criminal act (Iowa DHS, 2011, 2017f).

### PRECURSORS TO THE MANUFACTURE OF METHAMPHETAMINE

- Ephedrine or pseudoephedrine
- Lithium batteries
- Starter fluid
- Rock or table salt
- Drain cleaner
- Camping fuel
- Sulfuric acid
- Acetone
- Heet (gas additives)
- Paint thinner
- Iodine
- Brake cleaner
- Toluene
- Muriatic acid
- Anhydrous ammonia
- Matchbooks
- Coffee filters
- Aluminum foil
- Assorted glassware
- Propane tanks
- Coolers
- Plastic soda bottles
CASE

Diego, Age 3
Diego is a 3-year-old male child. While investigating a report that Diego’s older sibling may have been sexually abused, the DHS caseworker discovers that methamphetamine is being manufactured in a horse trailer that is parked in the driveway of the boys’ home. Diego undergoes a medical screening exam because he is a potentially drug-endangered child. He tests positive for methamphetamine and is placed in foster care.

BESTIALITY IN THE PRESENCE OF A MINOR

Bestiality in the presence of a minor is defined as the commission of a sex act with an animal in the presence of a minor as described in Iowa Code 717C.1 by a person who resides in a home with a child, as the result of the acts or omissions of a person responsible for the care of the child. DHS must report this type of allegation to law enforcement, as this is a criminal act (Iowa DHS, 2017b).

allows access by a registered sex offender / person required to register or on the sex offender registry

As described in Iowa Code 726.6 (Iowa DHS, 2017h), it is child abuse if a caretaker knowingly allows unsupervised access to a child by a registered sex offender or allows a registered sex offender to have custody or control of a child up to age 14 or a child up to age 18 if the child has a mental or physical disability. There is an exception if the registered sex offender is the caretaker’s spouse or is a minor child of the caretaker. DHS must report any suspicion of this type of child abuse to law enforcement, as it is a criminal act.

allows access to obscene material

This type of abuse is defined as a caretaker knowingly allowing a child access to obscene material, exhibiting obscene material to a child, or disseminating obscene material to a child (Iowa DHS, 2017a), as defined in Iowa Code 728.1.

<table>
<thead>
<tr>
<th>Obscene Material According to Iowa Law</th>
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<tbody>
<tr>
<td><strong>Material</strong></td>
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<tr>
<td>Any book, magazine, newspaper, or other printed or written material</td>
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<tr>
<td>Any picture, drawing, photograph, motion picture, other pictorial representation, statue, or other figure</td>
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<td>Any recording; transcription; or mechanical, chemical or electrical reproduction</td>
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PREVALENCE AND RISK FACTORS

In 2015 the DHS in Iowa conducted 24,298 assessments for child abuse. During that year, 8,298 children were found to be subjected to abuse or neglect, and 49% of these abused or neglected children were five years of age or younger. Sixty-four percent of child abuse assessments resulted in a finding of “no abuse,” which was similar to past years. The table below compares 2015 data to that from 2014 and 2013 (Iowa DHS, 2015b, 2014, 2013).

<table>
<thead>
<tr>
<th>CONFIRMED REPORTS OF CHILD MALTREATMENT BY TYPE</th>
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<tr>
<td><strong>Type of Abuse</strong></td>
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<tr>
<td>2013</td>
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<tr>
<td>Denial of critical care</td>
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<tr>
<td>Physical</td>
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<tr>
<td>Presence of illegal drugs in the body</td>
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<tr>
<td>Sexual</td>
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Risk Factors

Health professionals need to be alert to individual, relational, community, and societal factors that increase the risk of child maltreatment. The Centers for Disease Control and Prevention (CDC, 2016) cites these risk factors as contributing to child abuse:

- Children who are younger than 4 years of age
- Special needs that may increase caregiver burden (e.g., disabilities [including developmental or intellectual], mental health issues, and chronic physical illnesses). Lack of parental understanding of children’s needs, child development, and parenting skills
- Parental history of child maltreatment in his or her family of origin
- Substance abuse and/or mental health issues, including depression in the family
- Parental characteristics such as young age, low education, single parenthood, large number of dependent children, and low income
- Nonbiological, transient caregivers in the home (e.g., mother’s male partner)
- Parental thoughts and emotions that tend to support or justify maltreatment behaviors
- Social isolation
- Family disorganization, dissolution, and violence, including intimate partner violence
Parenting stress, poor parent-child relationships, and negative interactions

Community violence

Concentrated neighborhood disadvantage (e.g., high poverty, residential instability, high unemployment rates, and high density of alcohol outlets)

Poor social connections

Risk factors for human trafficking among youth populations include those youth:

- In the foster care system
- Who identify as LGBTQI
- Who are homeless or runaway
- With disabilities
- With mental health or substance abuse disorders
- With a history of sexual abuse
- With a history of being involved in the welfare system
- Who identify as native or aboriginal
- With family dysfunction

The presence of these factors signals the need for the health professional to examine the situation more closely, carefully, and methodically. These risk factors seldom appear in isolation but rather in clusters.

**ADVERSE CHILDHOOD EXPERIENCES (ACE)**

In a survey of 17,421 adults, a significant number reporting experiencing the following adverse childhood experiences:

**Abuse**
- Psychological, 11%
- Physical, 28%
- Sexual, 21%

**Neglect**
- Emotional, 15%
- Physical, 10%
Household Dysfunction

- Substance abuse, 27%
- Parental separation and/or divorce, 23%
- Mental illness, 17%
- Battered mother, 13%
- Criminal behavior, 6%

Source: Larkin et al., 2012.

Iowa’s Safe Haven Act

**Iowa’s Safe Haven Act**, enacted in 2002, allows parents or another person who has the parent’s authorization to leave an infant up to 14 days old at a hospital or healthcare facility that is open 24 hours a day, 7 days a week (“safe haven”) without fear of prosecution for abandonment. At least 20 children have been left at safe havens since the Iowa law was enacted.

The Safe Haven Act requires the hospitals or healthcare facilities to:

- Notify the Iowa Department of Human Services as soon as possible by calling 800-362-2178 to report that physical custody of an infant has been taken under the Safe Haven Act. DHS will make the necessary court and legal contacts and assume care, control, and custody of the child.

- Submit the certificate of birth report as required in Iowa Code section 144.14. If unknown, the place where the child was found shall be entered as the place of birth and the date of birth shall be determined by approximation.

- Keep confidential any information received or recorded in connection with a good faith effort to voluntarily release an infant under the Safe Haven Act except as outlined in 2001 Iowa Acts SF 355. Failure to keep information confidential is a serious misdemeanor.

According to the act, hospital or healthcare facilities may:

- Ask but cannot require the name of the parent(s), medical history of the infant, and/or the medical history of the infant’s parents.

- Perform reasonable acts to protect the physical health and safety of the infant with immunity from criminal or civil liability or omissions made in good faith.

- Testify at any court hearing held concerning the infant.

(Iowa DHS, 2017m)

*(For more information, see “Resources” at the end of this course.)*
RECOGNIZING PHYSICAL ABUSE

Physical Signs of Physical Abuse

Healthcare professionals need to be alert to physical injuries that are unexplained or inconsistent with the parent or other caretaker’s explanation and/or the developmental state of the child.

BRUIISING AND WELTS

Bruising should always generate suspicion in infants who are not yet mobile. The normal activities of daily life in an infant should not generate bruises, and if bruises are observed, the parent should be able to provide a reasonable explanation for their presence. If suspicious bruising is observed, the child should undergo a complete examination to check for other injuries.

Normal accidental bruising in children is generally seen over bony prominences. A careful history should be taken when bruising is observed in suspicious areas such as the back, posterior thighs and calves, or buttocks.

It is important to know both normal and suspicious bruising patterns when assessing children’s injuries. (Source: Research Foundation of State University of New York, 2006.)
Unexplained bruises and welts that arouse suspicions of physical abuse include bruises that:

- Are in various stages of healing
- Form a regular pattern that reflects the shape of an object used to cause the injury (e.g., belt buckle)
- Are located in areas that are not normally visible, such as the buttocks, chest, torso, and thighs
- Appear on both sides of the head or body, since accidental injuries generally occur on only one side of the body
- Are not accounted for by a logical explanation (e.g., the caregiver’s explanation of the injuries are not consistent with the injury or with the child’s account if the child is old enough to communicate
- Regularly noted after absence from school or daycare (e.g., after a weekend or a vacation)  
  (Joyful Heart Foundation, 2016; Kidshealth.org, 2015)

This pattern signals the blow of a hand to the face of a child.  
(Source: NYS OCFS, 2006.)

Regular patterns reveal that a looped cord was used to inflict injury on this child. (Source: NYS OCFS, 2006.)
History and physical findings dictate what diagnostic studies should be conducted. These may include:

- Basic bleeding evaluation if a bleeding problem is suspected
- Toxicology screening if ingestion of a toxic substance is suspected
- Screening for abdominal injury in children younger than 5 years of age in whom abuse is suspected even if there is no clear external evidence of abdominal injury
- Skeletal survey of children with fractures or who have been hit by objects
- CT scanning as indicated by injuries
- MRI as indicated to further define injuries
  (Giardino, 2016)

**LACERATIONS OR ABRASIONS**

Unexplained lacerations and abrasions are typically indicated by their appearance:

- To mouth, lips, gums, eyes
- To external genitalia
- On backs of arms, legs, or torso
- Human bite marks (these compress the flesh, in contrast to animal bites, which tear the flesh and leave narrower teeth imprints)
  (Joyful Heart Foundation, 2016; Kidshealth.org, 2015)

**BURNS**

Unexplained burns are typically indicated by the appearance of:

- Patterned contact burns in the shape of a hot object such as a cigarette or a curling iron
- Immersion burns by scalding water (sock-like, glove-like, doughnut-shaped on buttocks or genitalia; “dunking syndrome”)
- Rope burns on the arms, ankles, neck, torso, and wrists
  (Joyful Heart Foundation, 2016; Kidshealth.org, 2015)
A steam iron was used to inflict injury on this child.
(Source: Research Foundation of SUNY, 2006.)

FRACTURES

Unexplained fractures are typically indicated by the appearance of:

- Fractures to the skull, nose, or facial structure
- Skeletal trauma combined with other injuries, such as dislocations
- Multiple or spiral fractures
- Fractures in various stages of healing
- Swollen or tender limbs

HEAD INJURIES

Unexplained head injuries are typically indicated by the appearance of:

- An absence of hair and/or hemorrhaging beneath the scalp due to vigorous hair pulling
- A subdural hematoma (a hemorrhage beneath the outer covering of the brain, due to severe hitting or shaking)
- Retinal hemorrhage or detachment, due to shaking
- Whiplash, or “shaken baby syndrome” (see “Abusive Head Trauma” below)
- Eye injury
- Jaw and nasal fractures
- Tooth or frenulum (of the tongue or lips) injury
  (Giardino, 2016; Joyful Heart Foundation, 2016; Kidshealth.org, 2015)
ABUSIVE HEAD TRAUMA

Abusive head trauma (AHT), formerly known as shaken baby syndrome, occurs when a child is shaken, dropped, or struck directly on the head. Most instances of AHT occur in children less than 1 year of age. It only takes a few seconds to cause brain damage due to AHT.

Signs and symptoms of abusive head trauma may include:

- Lethargy/decreased muscle tone
- Extreme irritability
- Retinal hemorrhages
- Skull fractures
- Lethargy
- Diminished smiling or vocalizing
- Decreased appetite, poor feeding, or vomiting for no apparent reason
- Absence of smiling or vocalization
- Poor sucking or swallowing
- Rigidity or posturing
- Difficulty breathing
- Seizures
- Larger than usual head or forehead circumference
- Fontanel (soft spot) bulging
- Inability to lift head
- Inability of eyes to focus or track movement; unequal pupil size
- Vomiting


Behavioral Indicators of Physical Abuse

Careful assessment of a child’s behavior may also indicate physical abuse, even in the absence of obvious physical injury. Behavioral indicators of physical abuse include:

- Shows fear of parents or going home
- Apprehensive when other children cry
- Exhibits aggressive, destructive, or disruptive behavior
- Exhibits passive, withdrawn, or emotionless behavior
- Reports injury by parents
- Displays risk-taking behaviors
  - Self-injurious behaviors (e.g., cutting)
  - Psychoneurotic reactions (e.g., obsessions, phobias, compulsiveness, hypochondria)
- Wears long sleeves or other concealing clothing, even in hot weather, to hide physical injuries
- Seeks affection from any adult
- Regresses to an earlier developmental stage
- Develops speech disorders
  (Joyful Heart Foundation, 2016; MedicineNet.com, 2016)

**MUNCHAUSEN SYNDROME BY PROXY (MSBP)**

Munchausen syndrome by proxy is a relatively uncommon type of child abuse characterized by the abuser’s fabrication of the child’s illness or injury or by an exaggeration of illnesses, injuries, or symptoms. The person who most often commits MSBP is the child’s mother. MSBP is considered to be a mental illness. The abuser commits this type of abuse in an attempt to gain attention, sympathy, a sense of control, and/or satisfaction from deceiving persons.

Signs of MBPS include:

- The child has many medical problems that do not respond to treatment or that have an unusual course of progression.
- The results from physical assessments or laboratory tests are unusual and do not correlate with the child’s medical history or are found to be clinically impossible.
- Parents or caregivers are not comforted by good news about the child’s condition. They insist that the child is seriously ill despite clinical findings.
- The child’s signs and symptoms improve when not with parents or caregivers (e.g., when the child is hospitalized).
- Parents or caregivers insist on additional diagnostic tests, consultations, and/or transfers to other healthcare facilities.

RECOGNIZING PHYSICAL AND EMOTIONAL NEGLECT

Physical Neglect

Indicators of physical neglect include:

- Consistent hunger
- Poor hygiene (skin, teeth, ears, etc.)
- Inappropriate dress for the season
- Failure to thrive (physically or emotionally)
- Positive indication of toxic exposure, especially in newborns, such as drug withdrawal symptoms, tremors, etc.
- Delayed physical development
- Speech disorders
- Consistent lack of supervision, especially in dangerous activities or for long periods of time
- Unattended physical problems or medical or dental needs
- Chronic truancy
- Abandonment
  (Healthyplace.com, 2015)

Emotional Neglect

A child may demonstrate behavioral indicators of neglect such as:

- Begging for or stealing food
- Extended stays at school (early arrival or late departure)
- Constant fatigue, listlessness, or falling asleep in class
- Alcohol or other substance abuse
- Delinquency, such as thefts
- Reports there is no caretaker at home
- Runaway behavior
- Habit disorders (sucking, nail biting, rocking, etc.)
• Conduct disorders (antisocial or destructive behaviors)
• Neurotic traits (sleep disorders, inhibition of play)
• Psychoneurotic reactions (hysteria, obsessive-compulsive behaviors, phobias, hypochondria)
• Extreme behavior (compliant or passive, aggressive or demanding)
• Overly adaptive behavior (inappropriately adult, inappropriately infantile)
• Delays in mental and/or emotional development
• Suicide attempt
• Demands for constant attention and/or affection (Healthyplace.com, 2015)

A parent or guardian exhibiting the following behavioral indicators may be emotionally maltreating/neglecting the child:

• Treats children in the family unequally
• Seems not to care much about the child’s problems
• Does not show interest in the child’s feelings or activities
• Blames or belittles the child without cause
• Is cold and rejecting
• Behaves inconsistently toward the child
• Isolates the child from others
• Withholds affection as a means of punishment
• Expects the child to behave more maturely than is age appropriate
• Expects the child to excel academically or athletically beyond the child’s ability (Prevent Child Abuse New York, n.d.b)

**RECOGNIZING SEXUAL ABUSE**

Child sexual abuse involves the coercion of a dependent, developmentally immature person to commit a sexual act with someone older. For example, an adult may sexually abuse a child or adolescent, or an older child or adolescent may abuse a younger child.

Detecting child sexual abuse can be very difficult. Physical evidence is not apparent in most cases, and victims fear the consequences of reporting their “secret.” Most perpetrators of child sexual abuse are people who are known to the victim. In more than half of cases of repeated
abuse, the perpetrator is a member of the family. Anyone, even a mother, can be a perpetrator, but most are male.

The fact that such abuse is carried out by a family member or friend further increases the child’s reluctance to disclose the abuse, as does shame and guilt plus the fear of not being believed. The child may fear being hurt or even killed for telling the truth and may keep the abuse secret rather than risk the consequences of disclosure. Very young children may not have sufficient language skills or vocabulary to describe what happened.

Child sexual abuse is found in every race, culture, and class throughout society. Girls are sexually abused more often than boys; however, this may be due to boys’—and later, men’s—tendency not to report their victimization. There is no particular profile of a child molester or of the typical victim. Even someone highly respected in the community—the parish priest, a teacher, or coach—may be guilty of child sexual abuse. The majority of perpetrators of child sexual abuse were once victims themselves, but not all victims will become perpetrators.

Negative effects of sexual abuse vary from person to person and range from mild to severe in both the short and long term. Victims may exhibit anxiety, difficulty concentrating, and depression. They may develop eating disorders, self-injury behaviors, substance abuse, or suicide. The effects of childhood sexual abuse often persist into adulthood (Prevent Child Abuse New York, n.d.a).

**Physical Indicators of Sexual Abuse**

Physical evidence of sexual abuse may be not be present or may be overlooked. Victims of child sexual abuse are seldom injured due to the nature of the acts. Most perpetrators of child sexual abuse go to great lengths to “groom” the children by rewarding them with gifts and attention and try to avoid causing them pain in order to insure that the relationship will continue.

If physical indicators occur, they may include:

- Symptoms of sexually transmitted diseases, including oral infections, especially in preteens
- Difficulty in walking or sitting
- Torn, stained, or bloody underwear
- Pain, itching, bruising, or bleeding in the genital or anal area
- Bruises to the hard or soft palate
- Pregnancy, especially in early adolescence
- Painful discharge of urine and/or repeated urinary infections
- Foreign bodies in the vagina or rectum

(Prevent Child Abuse New York, n.d.a)
Behavioral Indicators of Sexual Abuse

Children’s behavioral indicators of child sexual abuse include:

- Unwillingness to change clothes for or participate in physical education activities
- Withdrawal, fantasy, or regressive behavior, such as returning to bedwetting or thumb-sucking
- Bizarre, suggestive, or promiscuous sexual behavior or knowledge
- Reporting sexual assault by their caretaker
- Prostitution
- Forcing sexual acts on other children
- Extreme fear of closeness or physical examination
- Suicide attempts or other self-injurious behaviors

Sexually abusive parents/guardians may:

- Be very protective or jealous of the child
- Encourage the child to engage in prostitution or sexual acts in the presence of the caretaker
- Misuse alcohol or other drugs
- Live in a geographically isolated area
- Lack social and emotional contacts outside the family
- Suffer low self-esteem
  (Prevent Child Abuse New York, n.d.a)

RECOGNIZING CHILD SEX TRAFFICKING

Child sex trafficking victims are abused physically, psychologically, and emotionally. The perpetrator controls these victims even when they are not physically restrained or confined by their trafficker.

An estimated 80% to 90% of trafficked adolescents were victims of child sexual abuse. Experts suggest that a runaway adolescent is likely to be approached by a pimp or invited to participate in a form of commercial sex within 48 hours of being on the street. The average age of entry into the commercial sex industry is 12 to 14 years.
Victim Identification/Warning Signs

- Involvement in the commercial sex industry in any way
- Record of prior arrest for prostitution or related charges
- An explicitly sexual online profile
- Excessive frequenting or internet chat rooms or classified sites
- Depicting elements of sexual exploitation in drawing, poetry, or other modes of creative expression
- Frequent or multiple sexually transmitted infections or pregnancies
- Lying about or not being aware of their true age
- Having no knowledge of personal data, such as age, name, or date of birth
- Having no identification
- Wearing sexually provocative clothing
- Wearing new clothing, getting hair or nails done with no financial means
- Secrecy about whereabouts
- Having late nights or unusual hours
- Having a tattoo and a reluctance to explain it
- Being in a controlling or dominating relationship
- Exhibiting hypervigilance or paranoid behaviors
- Expressing interest in or being in relationships with adults or much older people

Screening

Victims of sex trafficking are often accompanied by their pimp, whom they may refer to as their “boyfriend.” If trafficking is suspected, the two must be separated by the healthcare professional, for instance, assuring them that privacy for a physical exam is standard practice. Suggested questions when speaking with a child suspected to be a victim of trafficking include:

- Are you able to go to your home or job at will? Are you able to leave when you want to?
- Are you ever locked in at home or at work?
- Has anyone ever hurt you at home or on the job?
- Is anyone making you to do things you do not want to do at home or at work?
- Do you have full access to food, the bedroom, and the bathroom, or do you have to
ask permission?

- Has anyone ever taken away your food or water?
- Has anyone ever not allowed you to sleep?
- Have you ever wanted to go the doctor or dentist, but you weren’t allowed?
- Has anyone ever threatened your family?
- Has anyone taken your driver’s license/passport/papers?


RECOGNIZING AND RESPONDING TO VICTIMS’ DISCLOSURES

Victims of child abuse often feel helpless and hopeless and think that no one can do anything to help them. They may also attempt to protect an abusive parent or be reluctant to report any abuse for fear of the consequences. Therefore, abuse may continue for months and even years, particularly if the abuser is someone close to the child.

Victimized children may cry out in a variety of nonverbal or indirect ways, for example, a drawing left behind for the teacher, the counselor, or a trusted relative to see. Some children report vague somatic symptoms to the school nurse, hoping the nurse will guess what happened. To the child, this indirect approach is not betrayal of the abuser and, therefore, not grounds for punishment.

Some children may come to a trusted teacher or other professional and talk directly and specifically about their situation if that person has established a safe, nurturing environment and a sense of trust. More commonly, however, abused children use other, less direct approaches, such as:

- **Indirect hints.** “My brother wouldn’t let me sleep last night.” “My babysitter keeps bothering me.” Appropriate responses would be invitations to say more, such as “Is it something you are happy about?” and open-ended questions such as “Can you tell me more?” or “What do you mean?” Gently encourage the child to be more specific. Let the child use his or her own language and don’t suggest other words to the child.

- **Disguised disclosure.** “What would happen if a girl told someone her mother beat her?” “I know someone who is being touched in a bad way.” An appropriate response would be to encourage the child to state what he or she knows about the “other child.” It is probable that the child will eventually divulge who the abused child really is.

- **Disclosure with strings attached.** “I have a problem, but if I tell you about it, you have to promise not to tell anyone else.” Most children know that negative consequences can result if they break the silence about abuse. Appropriate responses would include letting
the child know you want to help him or her and telling the child, from the beginning, that there are times when you too may need to get some other special people involved. (Botash, 2015; Magana, 2015; Research Foundation of SUNY, 2006)

### Talking With Children Who Are Suspected of Being Abused

<table>
<thead>
<tr>
<th>Do</th>
<th>Don’t</th>
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<tbody>
<tr>
<td>• Separate the child from the suspected abuser</td>
<td>• Overreact</td>
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<tr>
<td>• Find a private place</td>
<td>• Make judgments</td>
</tr>
<tr>
<td>• Remain calm</td>
<td>• Make promises</td>
</tr>
<tr>
<td>• Be honest, open, and up-front with the child</td>
<td>• Interrogate the child or try to investigate (this is especially important in sexual abuse cases)</td>
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<tr>
<td>• Remain supportive</td>
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<tr>
<td>• Listen to the child</td>
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<tr>
<td>• Emphasize that the abuse is not the child’s fault</td>
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<tr>
<td>• Report the situation immediately</td>
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Sources: Botash, 2015; Magana, 2015; Research Foundation of SUNY, 2006.

### Case

#### Haley, Age 12

While working as a triage nurse in the emergency department, Katy initially screens a mother and her 12-year-old daughter, Haley. The mother tells the triage nurse that her daughter has a bladder infection. The girl’s urinalysis is normal. The doctor performs an external genital exam that reveals numerous vesicular lesions on Haley’s labia. The child denies any sexual activity. The doctor cultures the lesions for herpes and asks the mother to step into his office to discuss his findings.

Once Katy and Haley are alone in the exam room, Katy asks Haley if there is anything that she wants to talk about privately. Katy had noticed that Haley looked terrified and sat in silence while her mother did all of the talking. Haley shakes her head no, but Katy senses that she is holding something back. Haley then burst into tears and tells the nurse that her mother’s boyfriend has been rubbing his “private” on her and said that if she told anyone, her mother would go to jail.

Katy does not ask for more details. She calls CPS, and Haley is interviewed by a social worker with specialized training in forensic interview skills. Katy knows that if a victim of child sexual abuse is asked too many questions, he or she may not disclose the information to the child forensic interviewer, or might change his or her responses.

The next day, Haley undergoes a sexual abuse forensic exam in a child-friendly advocacy center. Haley and her mother, who was also a victim of child sexual abuse, receive counseling for over a year. The mother’s boyfriend is convicted of sexual abuse.
REPORTING CHILD ABUSE

The purpose of the **Iowa child abuse reporting law** is to provide the highest possible level of protection to children by encouraging the reporting of suspected abuse.

**Categories of Reporters**

There are two categories of reporters in Iowa: mandatory and permissive.

**MANDATORY REPORTERS**

Iowa law defines **mandatory reporters** as those who **must** make a report of child abuse within 24 hours when they reasonably believe that a child has suffered abuse. Mandatory reporters are professionals who have frequent contact with children and generally belong to one of six categories: health, mental health, education, law enforcement, child care, and social work.

Specific professionals in the health category include:

- Licensed physicians and surgeons
- Physician assistants
- Registered nurses
- Licensed practical nurses
- Dentists
- Licensed dental hygienists
- Optometrists
- Podiatrists
- Chiropractors
- Residents or interns in any of the professions listed above
- Basic and advanced emergency medical care providers

Mandatory reporters also include any of the following persons who, in the scope of professional practice or in their employment responsibilities, examine, attend, counsel, treat, or have the potential to interact with a child:

- Social worker
- Employee or operator of a public or private healthcare facility as defined in Iowa Code section 135C.1
- Certified psychologist
• Licensed school employee, certified paraeducator, or holder of a coaching authorization issued under Iowa Code section 272.31, or an instructor employed by a community college

• Employee or operator of a licensed child care center, registered child development home, Head Start program, Family Development and Self-Sufficiency Grant program under Iowa Code section 216A.107, or Healthy Opportunities for Parents to Experience Success – Healthy Families Iowa program under Iowa Code section 135.106

• Employee or operator of a licensed substance abuse program or facility licensed under Iowa Code Chapter 125

• Employee of an institution operated by DHS listed in Iowa Code section 218.1

• Employee or operator of a juvenile detention or juvenile shelter care facility approved under Iowa Code section 232.142

• Employee or operator of a foster care facility licensed or approved under Iowa Code Chapter 237

• Employee or operator of a mental health center

• Peace officer

• Counselor or mental health professional

• Employee or operator of a provider of services to children funded under a federally approved medical assistance home- and community-based services waiver

Clergy members are not considered to be mandatory reporters unless they are functioning as social workers, counselors, or in another role described as a mandatory reporter. If a member of clergy provides counseling services to a child and the child discloses an abuse allegation, then the clergy member is mandated to report as a counselor. (The counseling is provided to a child during the scope of the reporter’s profession as a counselor, not clergy.) (Iowa DHS, 2011)

PERMISSIVE REPORTERS

Any person may report suspected child abuse at any time and is encouraged to do so. All reports are confidential and may be made anonymously by members of the public. Permissive reporters are not mandated by law to report and are not entitled to any information from DHS pursuant to the report.

OTHERS WHO ARE REQUIRED TO REPORT

Iowa Administrative Code 441-175.23(2) mandates certified adoption investigators and DHS income maintenance workers to report suspected abuse. These reporters are required to report orally but do not need to make a written report, although they may do so if they wish. Like
permissive reporters, they will not receive any sort of written response from DHS unless they have another role with the child that would necessitate giving them access to a copy of the DHS report after it is completed.

When Must a Report Be Made?

According to Iowa Code 232.70, a mandatory reporter of child abuse who suspects that a child has been abused must make a report to the Department of Human Services (DHS). The law requires the reporter to report suspected child abuse to DHS orally within 24 hours of becoming aware of the situation. A **phone report should be made as soon as possible or within 24 hours by calling 800-362-2178.** A report in writing must be made within 48 hours after the oral report.

The employer or supervisor of a person who is a mandatory reporter shall not apply a policy, work rule, or other requirement that interferes with the person making a report of child abuse.

If a child is in imminent danger, the reporter must immediately contact law enforcement to provide immediate assistance to the child (Iowa DHS, 2017l). Law enforcement has the authority to take a child into protective custody in that situation. Such circumstances include the belief that immediate protection of the child is necessary, the discovery of additional crimes such as the manufacture of illicit drugs, or suspicion of the involvement of a registered sex offender. After notifying law enforcement, the reporter should call DHS.

While the law requires reporting of suspected child abuse, it is not the reporter’s role to validate the abuse. The law does not require proof that the abuse occurred before reporting. The law clearly specifies that reports of child abuse must be made when the person reporting “reasonably believes a child has suffered abuse” (Iowa DHS, 2011; U.S. DHHS, 2010).

**REASONABLE CAUSE**

**Certainty is not required.** The reporter need not be certain that the injury or condition was caused by neglect or by nonaccidental means. The reporter should only be able to entertain the possibility that it could have been neglect or nonaccidental in order to possess the necessary “reasonable cause.”

Source: Iowa DHS, 2011.
DIFFERENTIAL RESPONSE (DR)

The Iowa Department of Human Services began its Differential Response System in January 2014. This system consists of two pathways—Child Abuse Assessment (CAA) and Family Assessment (FA)—to respond to allegations of neglect and abuse.

The CAA pathway is taken when the child is in imminent danger. Examples of the need for CAA are the appearance of signs of physical abuse or if a child was found home alone without supervision and injured as a result of lack of supervision.

The FA pathway responds to less serious allegations of child neglect. The FA is conducted when the child was not found to be in imminent danger. Examples of the need for FA include situations of a home that was obviously dirty or if the child was found to be unsupervised and a block or more from home. In such cases, DHS offers a wide variety of services and supports to strengthen that family and help keep the child safe.

DR does not impact the criteria for accepting a report for assessment. Additionally, Iowa Code establishes a firm path for cases to be reassigned from the FA pathway to CAA pathway.

Findings from the Differential Response System Overview for 2015 showed that children who receive an FA are as safe as children who receive a CAA. In 2015, 95% of children who received a FA did not experience a substantiated abuse report within six months. Studies have also shown that a DR system can increase the legal pursuit of perpetrators of some of the most serious types of child abuse and neglect cases.


What Is Included in the Report?

Oral and written reports should contain all of the information given below that is known to the reporter:

- Names and home address of the child and the child’s parents or other persons believed to be responsible for the child’s care
- Child’s present whereabouts
- Child’s age
- Nature and extent of any injuries to the child, including any evidence of previous injuries
- Name(s), age(s), and condition(s) of other children in the same household
- Any other information the reporter believes may be helpful in establishing the cause of the abuse or neglect to the child

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• Identity of the person or persons responsible for the abuse or neglect to the child

• Reporter’s name and address

A specific form is not required to report abuse as long as all necessary information (as identified above) is included. However, the DHS does provide Form 470-0665, Report of Suspected Child Abuse, that may be downloaded from their website. (See “Resources” at the end of this course.)

PLACING A CHILD IN PROTECTIVE CUSTODY

Only law enforcement or physicians may take a child into protective custody without a court order or the consent of a parent or guardian according to Iowa Code 232.79. The child may be placed in protective custody if the child is in a situation that threatens the child’s life or health and there is not enough time to apply for a court order.

The authorized party who has taken custody of the child must make an attempt to immediately notify the parents, orally notify the court, and take the child to a location that is designated by the court for this purpose. A physician may admit the child to a hospital. The authorized party must notify the court in writing within 24 hours of this action.

What Happens Once a Report Is Made?

When the DHS receives a report of suspected child abuse, an assessment will be made according to DHS protocol. This protocol outlines a series of steps that allow for a comprehensive investigation in order to determine whether or not abuse has occurred and what intervention will take place to assist the child and his or her family.

The investigation consists of the following steps:

1. Intake
2. Case assignment
3. Evaluation of the alleged abuse
4. Determination of whether abuse occurred
5. Decision on placing a report on the Child Abuse Registry
6. Assessment of the family’s strengths and needs
7. Preparation of reports and forms

Descriptions, photographs, medical reports and records, reports from child protection centers, and any other pertinent reports (such as mental health center evaluations, treatment records, criminal records, law enforcement reports, and audio and video tapes) may be collected as part of the documentation (Iowa DHS, 2011).
GATHERING FORENSIC EVIDENCE

Whenever there are allegations of suspected child abuse or neglect, the mandated reporter should keep in mind that any records of physical findings may be used as evidence at a trial. Photos, diagrams, and accurate reporting of medical examination findings are invaluable. The mandated reporter should use language that is not open to misinterpretation when documenting findings.

If it is medically indicated, a healthcare practitioner in Iowa may obtain X-rays, take photos, or conduct medical testing or an examination that might provide medical indications for the child abuse assessment without consent of the parent or guardian.


LEGAL ISSUES FOR REPORTERS

Confidentiality

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes privacy provisions that have caused confusion and concern. Once a report of child abuse becomes a case, HIPAA rules around confidentiality and privileged communication no longer apply.

DHS has the authority to request information from any person believed to have knowledge of a child abuse case according to Iowa Code 232.71(b). In addition, no release is required for the professional expert who has access to the information involved in the assessment of abuse allegations and treatment planning.

Confidentiality is also waived by Iowa Code 232.74, which states:

Sections 622.9 (communication between husband and wife) and 622.10 (on communication in professional confidence) and any statute or rule of evidence which excludes or makes privileged the testimony of health practitioners or mental health professionals as to confidential communications do not apply to evidence regarding a child’s injuries or the cause of the injuries in any judicial proceeding, civil or criminal, resulting from a report of child abuse.

Physician privilege is waived in cases of suspected child abuse. Physicians are allowed to share whatever information is necessary with DHS to facilitate a thorough assessment.

It is a good idea for mandatory reporters to inform their clients of their status as child abuse reporters at the onset of treatment. Sharing of that information by providers may prevent the client from feeling betrayed if a report needs to be made. When a provider is able to support the family after a report has been made, the relationship that has been established with the child, and the family can remain positive throughout the assessment process (Iowa DHS, 2011).
Immunity

To encourage reporting of suspected child abuse and maltreatment, Iowa Code 232.73 provides immunity from any civil or criminal liability that might otherwise be incurred when a person participates in good faith in making a report, photographs, or X-rays; performing a medically relevant test; or assisting in an assessment of a child abuse report.

Penalties for Failure to Report

Iowa Code 232.75 provides for civil and criminal sanctions for failing to report child abuse. Any person, official, agency, or institution required to report a suspected case of child abuse that knowingly and willfully fails to do so is guilty of a simple misdemeanor and subject to criminal penalties. Likewise, any person, official, agency, or institution required by Iowa Code 232.69 to report a suspected case of child abuse who knowingly fails to do so, or who knowingly interferes with the making of such a report in violation of section 232.70, is civilly liable for the damages proximately caused by such failure or interference.

Failure to report also leads to broader repercussions. CPS cannot act until child abuse is identified and reported—that is, services cannot be offered to the family nor can the child be protected from further suffering (Research Foundation of SUNY, 2006).

PREVENTION OF CHILD ABUSE

Although there are a variety of approaches to address the prevention of child abuse that include reporting strategies and home visitation programs, a unique and effective approach to preventing child abuse is through the Community Partnerships for Protecting Children (CPPC). These community-based programs are offered through the Iowa DHS and operate under the belief that the safety of children is “everybody’s business.”

Individual strategies that have been used successfully by Community Partnerships include:

- **Family team meetings** to individualize services and supports for vulnerable children and their families
- **Neighborhood/community networking**, which may include connecting with domestic violence and substance abuse treatment agencies and faith-based organizations
- **Policy and practice change** within DHS
- **Shared decision-making** to include a variety of participants who plan and assess support services for families and children

(Iowa DHS, n.d.)
CASE

Lynne
Lynne, who is a nurse and single parent, recently moved to a new community. Finding only night-shift work and having no childcare resources, Lynne must leave her children, ages 8 and 10, alone while she works. Observing that the children are unattended at night, a neighbor contacts DHS. Through a CPPC Family Team Meeting, Lynne receives a list of childcare providers who are approved by DHS. Through neighborhood and community networking, Lynne is also introduced to a faith-based program that offers weekly dinners for families with children, where she is able to meet other community members in an informal setting. Lynne eventually finds a college student who is willing to stay with the children at night in exchange for room and board. After Lynne becomes well established in the community, she joins the local Shared Decision-Making Group to provide input about the needs of single parents who work at night.

RESOURCES

Iowa
Child Abuse Hotline (24 hours, 7 days)
800-362-2178

Child care overview (Iowa DHS)
http://dhs.iowa.gov/childcare/overview

Domestic Violence Hotline
800-942-0333

Report of Suspected Child Abuse (form) (Iowa DHS)

Safe Haven (Iowa DHS)
http://dhs.iowa.gov/safe-haven

Survivor services (Family Resources)
http://www.famres.org/services/survivor-services

National
American Professional Society on the Abuse of Children
http://www.apsac.org

Child Welfare Information Gateway (U.S. Department of Health and Human Services)
http://www.childwelfare.gov
National Center for Missing and Exploited Children
http://www.missingkids.com
800-THE-LOST (800-843-5678)

National Runaway Safeline
https://www.1800runaway.org/
800-RUNAWAY (800-786-2929)

Safe Horizon
http://www.safehorizon.org
800-621-HOPE (800-621-4673)

REFERENCES


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You must score 70% or better on the test and complete the course evaluation to earn a certificate of completion for this CE activity.

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ACCREDITATION INFORMATION FOR WILD IRIS MEDICAL EDUCATION
1. Which is **not** one of the categories comprising child abuse as defined in the Iowa Code?
   a. Physical abuse
   b. Denial of critical care
   c. Presence of illegal drugs in the home
   d. Allowing access to a registered sex offender

2. Which is an example of child abuse due to denial of critical care?
   a. A boy’s meals often consist of “junk food” because it is all his single mother can afford.
   b. A girl often wears ragged, dirty, and smelly clothes to school.
   c. An infant rides in a car driven by a mother who is intoxicated.
   d. A family lives in a cramped apartment with a leaky roof that the landlord refuses to repair.

3. A nurse in the neonatal intensive care unit is caring for a preterm infant who is difficult to console and has a high-pitched cry. The nurse suspects that the baby’s mother may have used illegal drugs during her pregnancy. The nurse’s best action is to:
   a. Ask the mother for her consent to test the baby’s urine for illegal drugs.
   b. Call Child Protective Services to report the baby’s possible exposure to illegal drugs in utero.
   c. Perform a drug screen using standing orders to detect illegal drugs in the baby’s urine.
   d. Recommend that the mother attend a Narcotics Anonymous meeting.

4. After learning about which situation must a DHS mandatory reporter for child abuse contact law enforcement?
   a. A 10-year-old girl’s after-school care is provided by her stepfather, who is a registered sex offender.
   b. A 10-year-old boy’s after-school care is provided by his uncle, who is a registered sex offender.
   c. An adolescent overdoses on cold pills containing ephedrine in an attempt to “get high.”
   d. An adolescent discovers a pornographic magazine hidden under the mattress in his parents’ bedroom.
5. Which is a **correct** statement regarding Iowa’s Safe Haven Act?
   a. Parents can avoid criminal prosecution when leaving an infant up to 30 days old in a suitable location if they notify authorities immediately.
   b. Parents can avoid criminal prosecution when leaving a newborn less than 14 days old in a healthcare facility that is open 24 hours a day, 7 days a week.
   c. Safe Haven facilities are required to obtain the names of the parents who abandon their child at the facility.
   d. Safe Haven facilities are not required to report the abandonment of a newborn infant if the infant was left in a suitable location and an appropriate person was notified.

6. At 10 p.m., the parents of a two-month-old female infant bring the newborn to the emergency department. The mother tells the triage nurse that her baby has been vomiting ever since dinnertime. When the nurse inquires about a bruise on the infant’s right temple, the mother explains that just before dinner that day, when she was carrying her baby through a doorway, the baby hit her head on the doorframe. The infant’s father corrects the mother by saying that the baby hit her head the day before. Which statement describes the nurse’s most appropriate assessment?
   a. The bruising of an infant who is not yet mobile arouses suspicion of abuse.
   b. Bruising such as this over a bony prominence is a normal finding for infants this age.
   c. The physician is unlikely to order a CT scan due to the risk it poses for infants.
   d. Since there are no other injuries on the infant, there is no cause to suspect abuse.

7. A school nurse notes that a 6-year-old female patient has abrasions on both knees, both palms, and the tip of her nose. In addition, the child’s lips are swollen and scabbed. The child says that she fell while roller-skating. The child lives with her mother, who is a single parent. The child is a very active girl, and her teacher reports that she participates in class and is popular with her peers. The nurse’s most appropriate action is to:
   a. Report the case to Child Protective Services because the pattern of injuries on the front of the girl’s body is a possible sign of abuse.
   b. Report the case to Child Protective Services because the child’s injuries resulted from an activity that is not developmentally appropriate for a 6-year-old.
   c. Report the case to Child Protective Services because the child’s single parent is at risk for high stress and more likely to commit abuse.
   d. Withhold reporting the case to Child Protective Services because the girl’s injuries are not highly indicative of abuse.

8. What is an indicator that a female adolescent may be a victim of sex trafficking?
   a. Being accompanied by a concerned father to a healthcare appointment
   b. Getting pulled over by the police for suspected drunk driving
   c. Reporting back pain related to a new exercise regimen
   d. Appearing consistently dehydrated and malnourished
9. When sexual abuse is suspected, the best way to interview a child is to:
   a. Use anatomical dolls.
   b. Reflect back to the child each part of his or her story to ensure correct recording of all the details.
   c. Use the child’s own terms for genitalia.
   d. Report the suspected abuse to CPS so that a forensic specialist can conduct the interview.

10. Mandatory child abuse reporters generally belong to one of six categories: health, mental health, education, law enforcement, child care, and:
    a. Clergy.
    b. Legal services.
    c. Government.
    d. Social work.

11. If child abuse is suspected but the child is not in immediate danger, mandatory reporters are required to make an oral report of suspected child abuse to the DHS:
    a. Within 24 hours.
    b. Within 48 hours.
    c. Immediately.
    d. After filing a written report.

12. Reasonable cause to suspect child abuse or maltreatment is defined as:
    a. Being certain that child maltreatment has occurred.
    b. Entertaining the possibility that an injury could have resulted from neglect or was nonaccidental.
    c. Having documented inconsistencies of how a physical injury occurred.
    d. Doubting the potential victim of abuse or neglect until he or she can provide supporting evidence.

13. Which is a correct statement concerning Iowa’s Differential Response System?
    a. The child abuse assessment (CAA) pathway is appropriate for a child who arrives at school on several occasions complaining of being hungry.
    b. The family assessment (FA) pathway is appropriate for an unsupervised child not found to be in imminent danger.
    c. Studies of the Differential Response System show that children who receive an FA are less safe than children who receive a CAA.
    d. Studies of the Differential Response System show that it hampers the legal pursuit of perpetrators of child abuse.
14. When a child is placed in protective custody, the authorized person’s action is to:
   a. Bring the child immediately to a place that is designated by the court for this purpose, unless the person is a physician treating the child and the child is or soon will be admitted to a hospital.
   b. Withhold information on the child’s whereabouts from the parent or other person legally responsible for the child’s care until the investigation of abuse has been completed.
   c. Notify the court in writing within 48 hours.
   d. Notify the court verbally within 24 hours.

15. The purpose of the DHS assessment protocol is to:
   a. Gather information to prepare to file criminal charges.
   b. Determine if abuse has occurred and what interventions are indicated.
   c. Justify requesting a court order to remove the child from the home.
   d. Protect reporters from criminal or administrative penalties.

16. When a person makes a good faith report of suspected child abuse, he or she:
   a. May still be held liable for damages in a civil lawsuit if it is determined that no abuse occurred.
   b. Cannot include health-related details that are protected by the Health Insurance Portability and Accountability Act (HIPAA).
   c. Is immune from civil or criminal liability related to making the report.
   d. Cannot provide evidence based on professional communications that are generally considered legally confidential.

17. A mandatory reporter who willfully fails to report a case of suspected child abuse:
   a. Is guilty of a felony.
   b. May not be held liable for damages caused by such failure.
   c. Is not guilty of a crime but may lose his or her professional license.
   d. May face both civil and criminal sanctions.