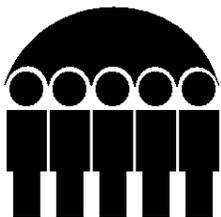


November 21, 2006

Employees' Manual
Title 17
Chapter B(4)

ADDITIONAL ASSESSMENT INFORMATION



Iowa
Department
of
Human Services

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Topic 1: Abuse Allegations

Link to [CPS Assessment Procedure](#)

Under Iowa law, categories of child abuse are as follows:

- ◆ [Physical abuse](#): Nonaccidental physical injury, or injury at variance with history or injury is reasonably inferred from the description of the caretaker's action
- ◆ [Mental injury](#): Impairment to psychological or intellectual capacity of child to function within the normal range of performance and behavior due to acts or omission of caretaker.
- ◆ [Sexual abuse](#): Sexual offense between child and caretaker, or assault with intent to commit a sexual offense, or child pornography or incest.
- ◆ [Denial of critical care](#): Failure to provide adequate food, shelter, clothing, health care, mental health care, or proper supervision or failure to respond to an infant's life-threatening condition.
- ◆ [Child prostitution](#): Sale, purchase, or offer for sale of the services of the child as a partner in a sex act, where the caretaker has allowed, permitted, or encouraged child to engage in prostitution.
- ◆ [Presence of illegal drugs](#): Presence of an illegal drug in the child's body that is a direct and foreseeable consequence of the acts or omission of the child's caretaker.
- ◆ [Manufacturing or possession of dangerous substances](#): Unlawful manufacture of a dangerous substance in the presence of the child, allowing the manufacture of a dangerous substance in the child's presence, or possessing a product containing ephedrine in the presence of a child with the intent of using it in the manufacture of a dangerous substance.
- ◆ [Bestiality in the presence of a minor](#): Sex act between a person and an animal in the presence of a child when the person resides in the home with the child and the act was committed due to the acts or omission of the caretaker.
- ◆ [Allows access by a registered sex offender](#): The caretaker knowingly allows a person custody or control of, or unsupervised access to a child or minor after knowing that the person is required to register or is listed on the Sex Offender Registry.

Topic 2: Procedures for Assessments in Out-of-Home Settings

Link to [CPS Assessment Procedure](#)

When the abuse report involves a child subject being cared for by a substitute caretaker away from the child's own home, there are several modifications to the requirements for completing the assessment.

Child abuse assessments in facilities have two distinct functions:

- ◆ To assess specific reports.
- ◆ To assess the relationship, if any, between the alleged abuse and the facility's policies and procedures.

When conducting a child abuse assessment in an out-of-home setting, determine the type of facility and the facility's licensing or regulating entity.

- ◆ The type of facility and the type of licensing will determine who is to be notified at the onset of an assessment and of the outcomes of the assessment. See [notification of assessment and outcomes](#).
- ◆ The Department of Human Services provides child abuse assessments in out-of-home settings with the following exceptions:
 - State-operated facilities such as the Glenwood and Woodward Resource Centers; the mental health institutes at Cherokee, Clarinda, Independence, and Mount Pleasant; the State Training School; the Iowa Juvenile Home at Toledo; and the Civil Commitment of Sexual Offenders Unit at Oakdale. (Refer reports of abuse in these facilities to the Department of Inspections and Appeals.)
 - Schools that are not also residential facilities.

Requirements Common to All Out-of-Home Settings

1. When the abuse allegation involves any out-of-home setting, assess the environment where the abuse occurred (not the child's home environment).

Assess the relationships between the person responsible for the abuse child subject and any other children to whom that person provides care.

2. When allegations involve multiple children who are not siblings or involve unrelated staff responsible for the abuse, start a separate assessment for each person.

3. If additional information or new reports surface, start a separate assessment.
4. As in all assessments, notify the child subject's parents in writing within five days of receiving the report, unless the juvenile court issues an order prohibiting notification.

Do **not** notify parents of other children for whom care is provided of the assessment or its outcome. (During the course of the assessment, you may interview other children or parents for information about the abuse, and thereby alert them their parents to the abuse report and assessment.)

5. Because of statutory requirements for record checks, notify regulatory staff when abuse is founded.

People named on the Central Abuse Registry as responsible for an abuse are prohibited from being employed in child-care settings, unless they obtain a positive evaluation of their ability to continue to work with children. (See [Record Check Evaluation, form 470-2310](#).)

Note: This requirement applies even when the abuse did not take place in the out-of-home setting. Therefore, you must notify the regulatory worker responsible for the facility when the following three conditions are met:

- ◆ The person named responsible for abuse is employed at, lives at, or regularly has access to children at a setting where children are cared for (regardless of whether the abuse took place in the out-of-home setting or a private home), **and**
 - ◆ The abuse was the result of the person's acts or omissions, and
 - ◆ The assessment results in placement on the Central Abuse Registry.
6. If you discover illegal operation by a facility during the course of an assessment (such as a nonregistered child-care home caring for more than six children), notify the service area manager and the county attorney in writing.

If you become aware of an allegation of a criminal act harming a child, contact law enforcement. See [Involving Law Enforcement](#).

Assessment Process in Out-of-Home Settings

1. When you are assigned a child abuse assessment involving a facility, make the following contacts:
 - ◆ **Regulatory worker for the facility.** Provide information regarding the report to the worker responsible for licensing, registration, or approval of the facility by the end of the next business day. (See the chart [Child Abuse Assessments in Out-of-Home Settings](#) to identify the applicable regulatory worker for the setting.)
 - Document your contacts with (or attempts to contact) the regulatory worker in the *Child Protective Services Assessment Summary*, form 470-3240.
 - Ask the regulatory worker to assist in conducting the assessment. The regulatory worker can provide information on whether the facility's policies and procedures comply with regulatory standards. This allows you to focus on the specific report of abuse.
 - Note:** It is not necessary for the regulatory worker to be present during every visit to the facility or for every interview conducted. Try to agree upon which aspects of the assessment you will do jointly or separately.
 - ◆ **Service caseworker for the child subject.** Contact the service caseworker for the child subject, if applicable. A child who resides in a foster care, juvenile detention, or substance abuse facility or in a psychiatric medical institution for children is likely to have a caseworker assigned.

Document these contacts (or attempts to contact) in the written *Child Protective Services Assessment Summary*. The caseworker can provide information about the child and the facility and may wish to participate in interviewing the child and other collateral sources.
 - ◆ **Contract monitoring worker** (project manager). When the Department purchases services from a facility, there is often a project manager assigned to the facility who needs to be informed about conditions there.

- ◆ **Facility administrator.** Inform the facility administrator of the report. Arrange to interview the child subject and other relevant collateral sources. Keep the administrator of the facility or the administrator's designee informed as to the progress of the assessment.

If the facility administrator is alleged to be the person responsible for the abuse, consult with supervisory staff regarding how to proceed with the assessment.
- 2. In all out-of-home settings, take reasonable efforts to address the safety of the child subject and other children in care. Consult with the facility administrator or designee as to how to achieve safety. Steps to address safety may include, but are not limited to:
 - ◆ Curtailing contact between the child and the person alleged to be responsible for the abuse.
 - ◆ Moving the child to another facility.
- 3. As in any assessment, observe and interview the child subject as necessary to address safety and interview (or offer to interview) the person alleged to be responsible for the abuse.
- 4. Contact and interview:
 - ◆ People believed to have been in the area when the incident occurred,
 - ◆ People believed to have knowledge about the incident, and
 - ◆ The supervisor of the person alleged to be responsible for the abuse.
- 5. Review any additional sources of information, such as:
 - ◆ The facility log
 - ◆ The child's facility case record
 - ◆ That personnel file of the person alleged to be responsible for the abuse
 - ◆ The facility's incident report
 - ◆ The facts and findings of any internal review conducted by the facility

Assessment Interviews in Facilities

Attempt to interview the child named as having been abused, the person alleged to be responsible for the abuse, and other people who may have relevant information regarding child's safety and the allegations.

- ◆ You are encouraged to team the assessment interview with the regulatory worker or other appropriate personnel. You may also utilize expert consultation (such as the local multidisciplinary team).
- ◆ Interviews should be tape recorded if possible. The witness should acknowledge that the statement is being recorded and consent to the recording. See [Electronic Recordings](#).
- ◆ Fully inform people alleged responsible for abuse of their appeal and record check evaluation rights.
- ◆ Verify quotes or statements from interviews (especially of facility employees) before including them in a report.

Physical Evidence in Facilities

1. Review written material such as facility logs and medical or education records.
 - ◆ The facility shall supply copies of pertinent information.
 - ◆ Do not remove the originals from the facility without facility consent, a court order, or a search warrant.
2. Observe objects such as restraints, handcuffs, weapons, or a knife wielded by an out-of-control child.

You may ask to have them turned over to you. However, do not remove objects from a facility without facility consent, a court order, or a search warrant.
3. You may take photographs of injuries, living arrangements, or other necessary items. Inform the facility before you take photographs.

Person Responsible for the Care of a Child in a Facility

Only an individual may be named as responsible for abuse of a child, not the facility itself.

1. To name supervisory or administrative personnel (up the chain of command) as responsible for the abuse of a child, you must establish that the person either:
 - ◆ Knew about the abusive situation and failed to respond to it, even though having the authority to do so; or
 - ◆ Implemented policies that were abusive and directed staff to follow those policies.
2. Seek supervisory consultation regarding this process. There must be clear documentation that these conditions existed in order to find that a person in higher level of authority is the person responsible for the abuse of a child.
3. Ask the following questions to help determine if such a finding is appropriate:
 - ◆ Did the person know about the abuse? When? Did the person take reasonable measures to protect the individual child? Was the child left in a high-risk situation? Did the abuse reoccur?
 - ◆ Did the person have the authority or the ability to intervene to protect the child? Did the person respond in a reasonable and prudent fashion?
 - ◆ Did the person participate in an act or decide to implement an act that resulted in injury to the child? Does the procedure as implemented fit the definition of child abuse?
 - ◆ Did the person direct another employee to commit an act that caused injury to a child or that could be considered abuse?
4. Give careful consideration before making a finding of abuse on a direct care worker when:
 - ◆ The worker is following the directive of the supervisor or the standard operating procedure at the facility, or
 - ◆ The abuse occurred because the facility has not implemented the regulatory standards in an appropriate manner.

Completion of Facility Assessments

1. Complete all required paperwork as in any other child abuse assessment. List the address and composition of the child's home household when abuse occurred in an out-of-home setting.
2. Share any registered incident with the licensing authority and with the facility administrator immediately.
3. If a child residing in a facility is adjudicated or pending adjudication as a child in need of assistance or as a delinquent, forward the written *Child Protective Assessment Summary*, form 470-3240, to the county attorney and to the juvenile court where the child legally resides.

NOTE: Following completion of the assessment, the licensing authority and the facility administrator have access to reports that are placed on the Central Abuse Registry.

NOTE: Rules governing facilities prohibit employment of people named on the Central Abuse Registry as responsible for the abuse of a child. (The Department may determine through evaluation that the report should not prohibit the employee's continued involvement with children.)

Foster Family and Child-Care Homes

[Form 470-3855, *Facility Assessment Checklist for Foster Family Homes*](#), lists the actions to be taken when assessing abuse allegations in a foster family home.

[Form 470-3854, *Facility Assessment Checklist for Child Care Homes*](#), lists actions to be taken when assessing abuse allegations in a child care home.

1. When the report involves a licensed foster home or a registered child development home, notify the Department's licensing or registration worker of the report by the end of the next business day.
 - ◆ Notify the Department's licensing worker even if the home study is conducted by a private child-placing agency.
 - ◆ Request the licensing or registration worker's assistance in conducting the assessment.

2. When a private social services agency did the licensing study for the foster home, notify the private agency's licensing worker of the report by the end of the next business day.

Ask the agency licensing worker to assist in conducting the assessment.

3. Also notify:
 - ◆ The purchase of service unit supervisor, if applicable.
 - ◆ The quality assurance and technical assistance personnel, if applicable.
 - ◆ The child subject's service worker, if the child has one.

Note: The licensing worker or child care registration staff can provide information to assist in determining if the abuse occurred as a result of inadequate recruitment, screening, or training of foster care or registered child care providers. The role of the foster family licensing worker or child care home registration worker during the assessment is to:

- ◆ Aid in addressing the safety of the children being provided care;
- ◆ Investigate for regulatory violations;
- ◆ Provide relevant information regarding the home;
- ◆ Assist in gathering assessment information, when possible;
- ◆ Provide support to the foster parents or child-care provider, as appropriate.

Refer to 12-F, [Assessments for Child Abuse Referrals](#), for Department policy on the role of child-care registration staff in assessing reports of abuse in a child-care home. See 12-B, [Reports of Mistreatment or Abuse](#), for Department policy on the role of foster family home licensing staff.

Procedure for Joint Assessment with Regulatory Staff

1. Notify the child care registration staff or foster family care licenser by the end of the next business day after receipt of the intake.
2. Plan a joint assessment with the regulatory staff, based on the known facts of the case, and initiate the assessment immediately.
 - ◆ The worker responsible for child care registration or foster family care licensing shall focus on compliance issues with the law and rules governing registration or licensure. Consult with the regulatory staff to identify any regulatory violations.
 - ◆ Make the first visit to the facility jointly with the regulatory staff if possible. Other joint visits may be advantageous to both the regulatory complaint investigation and the child abuse assessment.

- ◆ All child abuse allegations in a regulated setting are considered a complaint and require a response from regulatory staff. After the DHS regulatory worker has thoroughly investigated the referral, regulatory worker places documentation of the complaint in the regulatory file.

This information will not identify individual people, including children. Language in the documentation will not relate to child abuse, but will address compliance issues. The provider or foster parent is to be notified immediately of any corrective action necessary to meet minimum requirements.

3. Once you have completed the assessment, notify the foster family licensing or child development home registration worker immediately of your findings.

Note: Continuation of the home's foster family license or child care registration or payment may be prohibited if the name of any member of the household is placed on the Registry as a person responsible for the abuse of a child.

The Department must complete an evaluation to determine whether the person would pose a risk to children within a child-care or family foster home setting. See [Record Check Evaluation](#).

4. When an assessment of a **nonregistered** child-care home that receives child-care payment from the Department results in placement on the Registry, immediately notify the Child Care Assistance eligibility worker of that fact in writing.
 - ◆ Provide the name of the child subject, the name of the provider, and the names of other children who receive care, if known.
 - ◆ The Department must do a record check evaluation to determine if the founded report should prohibit payment for child care services.

Child Care Centers and Other Group Facilities

Procedures in this section apply to the following facilities that provide care to children:

- ◆ Child-care centers
- ◆ Community or comprehensive residential foster care facilities
- ◆ Shelter care facilities
- ◆ Juvenile detention centers
- ◆ Psychiatric medical institutions for children
- ◆ Substance abuse facilities

[Form 470-3853, Facility Assessment Checklist for Child Care Centers](#), lists actions to be taken when assessing abuse allegations in a child care center setting.

[Form 470-3856, Facility Assessment Checklist for Group Care](#), lists actions to be taken when assessing abuse allegations in a group residential facility.

1. If a report regarding a facility does not meet the criteria for assessment, notify the following as applicable:
 - ◆ Department of Inspection and Appeals (DIA)
 - ◆ The child care center licensing worker
 - ◆ The placement worker
 - ◆ The Department's contract monitoring personnel of the report
2. If a report regarding a facility does meet the criteria for assessment, notify the regulatory worker by the end of the next business day after receipt of intake.
3. Plan a joint assessment with the child care center licensing consultant or the group care facility DIA licensing surveyor, based on the known facts of the case, and initiate the assessment immediately.

The role of the child care center licensing consultant or the group care facility DIA licensing surveyor during the joint assessment is to:

- ◆ Aid in addressing the safety of the children being provided care,
- ◆ Investigate for regulatory violations,
- ◆ Provide relevant information regarding the facility,
- ◆ Assist in gathering assessment information, when possible, and
- ◆ Provide support to the facility as appropriate.

4. Consult with the child care consultant, for child care centers, or the Department of Inspections and Appeal's licensing staff, for group care facilities, to identify regulatory violations and prepare a notice to the facility. See [Notice to Facilities With Problems in Policy or Procedure](#).

Note: As in any other report, all factors must be present in order to accept a report of child abuse for assessment (child, caretaker, and incident).

A violation of a licensing rule does not automatically constitute a child abuse allegation. Violation of licensing standards may contribute to abuse. However even an egregious disregard of a licensing standard does not automatically confirm that abuse occurred.

Procedure for Joint Assessment With Child Care Consultant

The role of the DHS child-care center licensing consultant is specified at 12-E, [Investigations for Child Abuse Referrals](#).

1. Notify the child care consultant by the end of the next business day after receipt of referral.
2. Plan a joint assessment with the child care consultant based upon the known facts of the case, and initiate the assessment immediately.
 - ◆ The child care consultant's participation in assessment of the alleged abuse shall focus on compliance issues with the child care law and the requirements for licensing.
 - ◆ Make the first visit to the facility jointly with the child care consultant if possible. Other joint visits may be advantageous to both the regulatory investigation and the child abuse assessment. The first visit by the child care consultant shall occur within 24 hours.

Note: After the child-care consultant has thoroughly investigated referral regarding compliance with licensing rules, the consultant will place documentation and summary information in the licensing file. The consultant will notify the facility immediately of:

- ◆ Any corrective action necessary to meet minimum requirements.
- ◆ Any adverse action to suspend or revoke the license.

Use of Physical Restraint in Facilities

A report may allege physical abuse as the result of the use of physical restraint at a facility. Facilities may physically restrain a child to prevent the child from injuring self or others, damaging property, or engaging in extremely disruptive behaviors.

1. When assessing a report of physical abuse due to the use of physical restraint, consider:
 - ◆ Whether the restraint was reasonable, considering the precipitating situation.
 - ◆ The degree of injury to the child.
 - ◆ Attempts made to avoid injury.
 - ◆ Whether the injury is compatible with the explanation provided.
2. If a child living in a facility is adjudicated or pending adjudication as a child in need of assistance or as a delinquent, forward the written *Child Protective Assessment Summary*, form 470-3240, to the county attorney and to the juvenile court where the child legally resides.

Note: Following completion of the assessment, the licensing authority and the facility administrator have access to reports that are placed on the Central Abuse Registry.

Notice to Facilities With Problems in Policy or Procedure

1. Consult with the licensing worker in assessing the relationship between the alleged abuse and the facility's policies and procedures.
2. Prepare a "notice to facility" letter for any assessment in which you find problems with facility policy, practice, or compliance with licensing rules, regardless of whether abuse occurred.
 - ◆ Include sufficient information to identify the problem areas. Do not include any personally identifiable information about the subjects of the assessment.

- ◆ The letter must contain information about any of the following that apply:
 - A violation of facility policy noted during the course of the assessment.
 - An instance where facility policy or lack of policy may have contributed to the abuse.
 - An instance where general practice in a facility appears to differ from the facility's written policy.
 - An instance where the facility practice appears to be in violation of licensing standards.
 - ◆ Both you and your supervisor must sign the letter to the facility.
3. Send the letter to all of the following:
- ◆ The governing body of the facility.
 - ◆ The facility administrator.
 - ◆ The licensing authority for the facility.

For health care facilities not licensed or approved by the Department (such as hospitals), send the letter to the facility administrator and to the licensing or accrediting body for the facility.

For child care centers and homes, the licensing authority includes:

- ◆ Chief, Bureau of Child Care and Community Services, DHS Division of Child and Family Services, 1305 E. Walnut St., Iowa 50319-0114.
- ◆ The child-care consultant for the center or home.

For facilities licensed to provide overnight care, the licensing authority includes the following:

- ◆ Chief, Bureau of Protective Services, DHS Division of Child and Family Services, 1305 E. Walnut St., Des Moines, Iowa 50319-0114.
- ◆ Administrator, Division of Health Facilities, Department of Inspections and Appeals, 321 E. 12th St, Des Moines, Iowa 50319-0075.
- ◆ Chief, Bureau of Purchased of Services.

4. Offer the administrator of the facility an opportunity to meet with you to discuss findings of the report and any regulatory problems.

Topic 3: Courtesy Interviews for Child Abuse Assessments

Link to [CPS Assessment Procedure](#)

Upon request, all Department offices shall provide assistance to another office assessing an allegation of child abuse. Use the following procedure for courtesy interviews:

1. The requesting unit:
 - ◆ Telephones the other unit and requests a courtesy interview;
 - ◆ Explains the situation and forwards materials as necessary;
 - ◆ Also makes the request through the STAR system.

NOTE: The receiving unit shall not refuse the courtesy request.

2. The unit receiving the request conducts the courtesy interview:
 - ◆ Of the alleged victim within the observation time period assigned and
 - ◆ Of collateral contacts within one week of receiving the call or receiving the written materials necessary to conduct the interview.

Any variation from these time frames must be discussed and agreed upon between units.

3. The receiving unit telephones the results of the interview to the requesting unit immediately following completion of the interview.
4. The receiving unit follows this call with a written summary of the interview through the STAR system within five working days.

The receiving unit maintains a copy of the written summary until notified that the assessment has been completed.

5. If the interview was recorded, the interviewing unit forwards the recording to the requesting unit. (This recording does not substitute for the telephone call and written summary.)
6. The unit conducting the assessment confirms receipt of the written report from the unit that conducted the courtesy interview by providing that unit with notice that the assessment has been completed, and keeps a copy in the file.
7. Following receipt of the notice that the assessment has been completed, the unit that conducted the courtesy interview destroys its copy of the written report.

NOTE: When an assessment requires an interview with a subject who resides in another state, make every effort to secure the interview through a formal request to the child protective agency of the other state. Locate this agency through contact with Iowa's Central Abuse Registry.

If the other state refuses to conduct the interview, first consult with supervisory staff, then the service help desk to determine the best way to obtain information from the out-of-state subject.

Topic 4: Procedures for Emergency Placements

Link to [Procedure](#)

See also [Indian Child Welfare Acts](#)

Assessment workers do not have the legal authority to remove children from their home. Only a peace officer or a physician treating a child may remove a child without a court order. You may recommend that the juvenile court order the removal of a child from the parental home when you believe that the removal is necessary to avoid immediate threat to the child's life or emotional well-being.

Circumstances or conditions that may indicate the presence of imminent danger include but are not limited to:

- ◆ The refusal or failure of the person responsible for the care of the child to comply with the request of a peace officer, juvenile court officer, or child protection worker to obtain and provide to the requester the results of a physical or mental examination of the child. The request for a physical examination of the child may specify the performance of a medically relevant test.
- ◆ The refusal or failure of the person responsible for the care of the child or a person present in the person's home to comply with the request of a peace officer, juvenile court officer, or child protection worker to submit to a medically relevant test and provide the results to the requester.

Removing a child from the home is traumatic for parents and the child, even when all agree it is the best course of action. Removals create a new crisis for everyone involved. If the parents are available, try to involve them in the decision to leave the home or to place the children in placement.

Reasonable Efforts to Prevent Placement

Before determining a child to be unsafe and initiating emergency removal of a child, consider reasonable efforts to prevent placement, including:

- ◆ Bringing protective relatives to the child's home while the parents leave.
- ◆ Initiating community services such as public health visitor or visiting nurse services.
- ◆ Initiating homemaker services or family-centered services, dependent on abuse finding or court order.
- ◆ Implementing safety plan services, dependent on safety assessment or court order.

- ◆ Placing the child voluntarily with relatives or friends (make a diligent search for relatives).
- ◆ Placing the child in voluntary foster or shelter care.
- ◆ Obtaining a court order requiring that the person responsible for the abuse leave the home, when other family members are willing and able to protect the child adequately.
- ◆ Have the nonabusing caretaker move to a safe environment with the child.

Locating an Emergency Placement With Family or Friends

When there is an emergency need for the child to be moved from the child's home:

1. First, attempt to identify a relative who would be willing to take the child on a temporary basis pending the removal hearing. The noncustodial parent (if any) should be the first consideration, unless known concerns exist.
2. If the noncustodial parent is not an option, follow the procedures in [Relative Placements](#). Document in the case narrative:
 - ◆ The consideration of each of the identified relatives.
 - ◆ Why the relative was not selected as a placement resource, if applicable.
3. For relatives who do appear to have placement potential, ask the parent or caretaker to sign form [470-2115, Authorization for the Department to Release Information](#), giving you permission to contact these relatives. (If the parents have joint legal custody, you must get the permission of both parents to release the information.)
4. Contact the identified relative to see if the person will care for the child on a temporary basis. If so, facilitate the relative placement instead of requesting a court-ordered removal of the child. (See [Record Checks for Emergency Placements](#).) Follow local policy regarding consulting with a supervisor before making the placement decision.
5. When no relative placement is found, attempt to identify a non-relative adult, such as a friend or neighbor, who has a significant relationship with the child and can provide good care on a temporary basis. Go through the same evaluation process for these people. (However, it is not necessary to list and justify rejected candidates in the case record.)

Note: The time limit for a nonrelative placement is only 20 days, unless the home becomes licensed as a foster home.

6. If no **relative or nonrelative** placement is identified, proceed with court-ordered removal and placement of the child in an appropriate level of foster care. Document the efforts to place with a relative in the child's [Family Case Plan, form 470-3453](#).

Record Checks for Emergency Placements

When the child will be moving to a relative's home or to an appropriate nonrelative's home instead of entering foster care:

1. Obtain the person's date of birth and social security number.
2. Ask the person to disclose any child abuse or criminal record that the person may have. Inform the person that you will be checking child abuse registry and DCI records, and obtain the person's signature on form [595-1489, Non-Law Enforcement Record Check Request Form A](#).
3. Since the child will be moving before the record checks are completed, have the person sign a statement confirming that the person has no prior criminal or child abuse record. Example:

No one in my household has been convicted of a crime or has a record of founded child abuse.
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4. Advise the person that at any point during the placement process you will request the court to place the child elsewhere if:
 - ◆ There are any safety issues, or
 - ◆ The needs of the child are not being met, or
 - ◆ There is a lack of follow through on the permanency goal.
5. Submit the record checks within 24 hours whenever possible (or the next working day).
 - ◆ Check ACAN and STAR, as well as any open or closed service files concerning the relatives.
 - ◆ Check the sexual offender registry at www.iowasexoffender.com/ and document the results in the child's file. (For more information, see 12-B, [Sex Offender Registry](#).)

- ◆ For the criminal records check, submit both form 595-1489, Non-Law Enforcement Record Check Request Form A, and form [595-1494, Non-Law Enforcement Record Check Billing Form](#). (See form samples and instructions.)
 - Write "Relative Placement" on each form.
 - Indicate on both forms the name and number of the county where the child resides (or was removed from parental care), so the Division of Fiscal Management and can charge the cost to decategorization funds correctly.
 - Note on the billing form that this form is to be submitted to DHS Bureau of Purchasing, Payments, and Receipts.
 - Enter the codes: 0001 413 Pay Region # (01=Sioux City, 02=Waterloo, 03=Des Moines, 04=Council Bluffs, 05=Cedar Rapids).

Removal of a Child

1. Consider requesting an ex-parte order to separate the child from the person responsible for the abuse when you determine that:
 - ◆ The child is in imminent danger unless the child is separated from the person responsible for the abuse AND
 - ◆ Reasonable efforts to prevent emergency removal have been considered AND
 - ◆ Those efforts will not adequately safeguard the child.
2. If child removal is necessary, notify the supervisor and document the action in the *Child Protective Services Assessment Summary*, form 470-3240.
3. At the time of any removal:
 - ◆ Inform the parents that they may have parental liability obligations when their child is placed in foster care.
 - ◆ Provide the parents with the brochure, "What You Need to Know About Paying Child Support While Your Child is in Foster Care" (Comm. 136).
 - ◆ Inform the parents that the consequences of a permanent removal may include termination of the parent's right with respect to the child.
 - ◆ Provide the parents with the brochure, "The State Has My Child! What Can I Do?" (Comm. 146).

4. Document these actions in the *Child Protective Services Assessment Summary*.

If the child is removed from a FIP household, also notify the income maintenance worker assigned to the case of the removal.

5. If the child is not returned to the care of the parent or guardian, follow locally established procedures to file a petition with the juvenile court within 72 hours after the child's removal.

Removal by Ex Parte Order

1. Follow local procedures for requesting the juvenile court to issue an ex parte order for the removal of a child.
2. Regardless of local procedures, gather information to support all of the following:
 - ◆ The child's immediate removal is necessary to avoid imminent danger to the child's life or health;
 - ◆ There is not enough time to file a petition and hold a hearing concerning temporary removal under Iowa Code section 232.95;
 - ◆ The child cannot either be returned to the place where the child was residing or be placed with the parent who does not have physical care of the child; AND
 - ◆ One of the following applies:
 - The person responsible for the care of the child is absent, or though present, was asked and refused to consent to the removal of the child and was informed of the intent to apply for an order to remove the child; OR
 - There is reasonable cause to believe that a request for consent would further endanger the child; OR
 - There is reasonable cause to believe that a request for consent will cause the parent, guardian, or legal custodian to take flight with the child.

3. Unless the juvenile court has designated this responsibility to another:
 - ◆ Make every reasonable effort to inform the parent or other person legally responsible for the child's care.
 - ◆ Follow up with any inquiries that may aid the court in disposing of the application.
4. Prepare and file a written report within five working days that includes documentation of:
 - ◆ Conferences you held.
 - ◆ Efforts to inform the parents or other person legally responsible for the child's care of the application.
 - ◆ Any inquiries made to aid the court in disposing of the application.
 - ◆ All information communicated to the court.

Removal by Peace Officer

1. During the course of an assessment, immediately contact a peace officer and request assistance if you believe that the child is in a circumstance or condition that presents an imminent danger to the child's life or health unless removed from the parental home.
2. If you request that the peace officer conduct an emergency removal of the child, and the peace officer refuses, follow locally established procedures to contact juvenile court authorities to request an ex parte order to remove the child. Document these steps in the *Child Protective Services Assessment Summary*, form 470-3240.
3. If a law enforcement officer is at a parental home where there is no parent or other caretaker, and requests the assistance of the Department, comply with the request. This includes a request from law enforcement for:
 - ◆ Making a report of child abuse,
 - ◆ Assisting in caring for or placing children, or
 - ◆ Entering the home.

Removal by Physician

1. If a child receiving medical care is imminently likely to suffer significant injury or death if returned to the parental home, immediately request that the treating physician keep a child in custody, usually within the hospital setting.
2. If the physician keeps the child in custody in the hospital, inform the physician of the provisions of Iowa Code 232.79:
 - ◆ The physician must immediately orally inform the juvenile court of the emergency removal and the circumstances surrounding the removal.
 - ◆ Within 24 hours of orally informing the court of the removal, the physician shall inform the juvenile court in writing of the emergency removal and the circumstances surrounding the removal.
3. If the physician refuses to keep the child in protective custody, follow locally established procedures to contact juvenile court authorities to request an ex parte order to place the child in custody. Document these steps in the *Child Protective Services Assessment Summary*, form 470-3240.

Topic 5: Child Protection Centers

Link to [CPS Assessment Procedure](#)

The Department contracts with several “child protection centers” throughout the state to assist the Department child protection workers in assessing reports of child abuse.

In most cases, these centers provide medical evaluations and psychosocial assessments of the victim when there are allegations of sexual abuse. Child protection centers can assist in conducting child abuse assessments. However, taking reasonable measures to address the safety of the child remains the child protective worker’s responsibility.

A protocol establishes procedures between the child protection center and the Department. Provisions relevant to the expectations of the Department child protection workers are summarized as follows:

- ◆ **Referrals.** When you make a referral to a child protection center, there should be allegations of sexual abuse or physical abuse with bodily injury. Provide:
 - The child’s name, sex, birth date, and location.
 - The parent’s names, address, and phone number.
 - The names of the people accompanying the child to the child protection center.
 - Your name and phone number.
 - The law enforcement officer’s name, legal jurisdiction, identification number, and phone number.
- ◆ **Scheduling.** Try to schedule interviews and examinations during the center’s regular hours.
- ◆ **Source of payment.** Determine the source of payment on the telephone at the time of scheduling, if possible.
- ◆ **Consents.** If no parent or guardian will be accompanying the child to the child protection center, secure a consent or court order to examine the child. Provide this to the center at the time of the appointment, or provide verification that the Department has obtained emergency custody.
- ◆ **Registration and intake.** At the time of the appointment, ensure that necessary consent forms and authorizations are signed. Be prepared to brief the child protection center’s interviewer, in coordination with law enforcement, on the circumstances of the assault or existing allegations.
- ◆ **Interview.** When staff at a child protection center interviews a child, you may use that interview in place of an interview you conduct. This prevents the child from having to repeat the history of abuse. Be present in the observation room to monitor the interview of the child.

- ◆ **Team meeting.** After the interview and physical examination, you will participate in a team meeting to determine the appropriate plan of action, based on the findings of the interview and examination.

The team consists of the child protective worker, the law enforcement officer, the physician, and the interviewer. It may include other staff of the child protection center. Consultation with the county attorney's office may be needed for decision-making.

- ◆ **Documentation of center services.** The center will provide written reports to you. Incorporate relevant information from the center's report into the *Child Protective Services Assessment Summary*, form 470-3240. Keep the center's written documentation in the case file.

Videotapes the center makes during the course of the interview are also considered to be part of the assessment case record and are maintained according to Iowa Code Chapter 235A. If a subject of a report requests a copy of the child protection center's report or videotape, arrange to have it provided.

Provide the child protection center with a notice that the assessment has been completed and whether the incident has been placed on the Central Abuse Registry.

Topic 6: Payment for Medical Examinations or Services

Link to [CPS Assessment Procedure](#)

When necessary, special provisions exist for payment for:

- ◆ Photographs and x-rays
- ◆ Physical examinations or tests
- ◆ Sexual abuse examinations
- ◆ Mental health examinations
- ◆ Interpretive services
- ◆ Ongoing services for crime victims

Photographs, X-Rays, Physical Examinations, or Medical Tests

Mandatory reporters may take or arrange for photographs of injuries at public expense. Health practitioners may perform medically indicated examinations or tests at public expense if necessary for the completion of a child abuse assessment.

Attempt to cover costs related to x-rays or other medical examinations or test through Medicaid or other health insurance when available.

The Department will pay for drug testing of a child when:

- ◆ A health practitioner performed the test **before** or **during** a child abuse assessment because the practitioner determined that it was medically indicated.
- ◆ The test was performed **during** the assessment at the request of the Department.

The Department will pay for drug testing of the person alleged responsible for abuse when the test was performed **during** the assessment of an allegation of:

- ◆ Denial of critical care for failure to provide proper supervision, or
- ◆ Presence of illegal drugs in a child, or
- ◆ Manufacturing a dangerous substance or possession of a dangerous substance with the intent to manufacture.

Payment may also be made when:

- ◆ The drug test is scheduled before the conclusion of the assessment but cannot be administered before the completion of the assessment and the worker documents in the written report that an Addendum will be submitted that addresses the result of the drug test; or
- ◆ There is documentation in the written report that the worker requested or attempted to have the drug test done before completing the assessment but the test was performed after the conclusion of the assessment.

To obtain reimbursement for the cost of photographs and X-rays or other physical examinations or tests, the claimant must submit:

- ◆ An original invoice (required for payment of most services).
- ◆ Form [General Accounting Expenditure \(GAX\)](#) completed for each child.
- ◆ A cover letter directed to the DHS Division of Child and Family Services that contains:
 - The child's name, age, and address.
 - The name of the worker or unit to whom the photographs, x-rays, examinations, or tests were provided.
 - The date the photographs, x-rays, examinations, or tests were done.
 - A statement agreeing to retain the photographs, x-rays, examinations, or test results for five years or to agree to provide them to the Department for retention.

The claimant submits two copies of these documents to the Central Abuse Registry, DHS Division of Child and Family Services, 1305 E Walnut Street, 5th Floor, Des Moines, Iowa 50319-0114. See [17-Appendix](#) for more detailed instructions on preparing the GAX.

Examinations for Sexual Abuse

Direct those conducting medical examinations to assess a report of sexual abuse to seek payment from the Iowa Crime Victim Assistance Program by submitting a claim within 45 days to:

Crime Victim Assistance Program, Compensation Program,
Lucas Bldg. Ground Fl.,
321 E. 12th Street, Des Moines, IA 50319

Ongoing Services for Crime Victims

Refer the family to local law enforcement authorities for information about accessing treatment funds from the Crime Victim Assistance Program.

When asked to pay for services related to a child abuse assessment, the Crime Victims Assistance Program will request verification that the child was a victim of child abuse and verification of services.

Information about the Crime Victim Assistance Program is also available by phone at (515) 281-5044 or 1-800-373-5044.

Mental Health Examinations

When securing funds for a court-ordered mental health examination of a child to complete a child abuse assessment:

- ◆ Consult with your supervisor.
- ◆ Contact the local juvenile court administrator for assistance in securing funds.

Payment for Interpretive Services

Try to secure free interpretive services for interviews when possible. When necessary, you may use personal service contracts for interpretive services for interviews with non-English speaking clients. Follow locally established procedures for using this contract and for securing services for interviewing deaf clients.

Topic 7: Protective Disclosure

Link to [CPS Assessment Procedure](#)

In the course of an assessment, you may determine that it is necessary for the protection of a child that you inform a subject of the report that a person is:

- ◆ Listed in the Child Abuse Registry or Dependent Adult Abuse Registry, or
- ◆ Required to register with the Sex Offender Registry.

This disclosure can be made **only** to a subject of a child abuse assessment (a parent, guardian or custodian of a child, the child, the person alleged responsible, or the attorneys). (See [Definition of Terms Used in Intake and Assessment](#) for a list of people who are subjects of a child abuse report.)

Topic 8: Confirming Physical Abuse

Link to [Policy](#)

Physical abuse can take a variety of forms. While all instances of physical abuse result in injury to the child, not all child injuries are a result of physical abuse. It is important to analyze circumstances around an injury to determine whether or not the injury constitutes physical abuse.

To confirm any allegation of physical abuse, gather and document credible evidence that the following factors are present:

- Factor 1:** The victim is a **child**.
- Factor 2:** The person responsible for the abuse was a **caretaker** for the child at the time of the abuse.
- Factor 3:** A **physical injury** to the child has occurred.

Examples of credible evidence of physical injury include:

- ◆ Visual observation by the protective worker of external visible injuries including, but not limited to:
 - Abrasions
 - Lacerations
 - Scalds
 - Burns
 - Eye injuries (including detached retina)
 - Bruises
 - Welts (raised area on surface tissue, caused by blow)
 - Hyperemia (reddening of surface tissue) lasting 24 hours or more
(**Note:** This is the only injury that involves the 24 hour standard.)

Supportive documentation must include a precise description of the size, shape, color, type and location of the injury.

If minor injuries occur, consider consulting with a physician to determine whether these injuries would have required a healing process.

- ◆ Visual observation by a credible person of visible external injuries. If possible, information obtained from the person should include a precise description of the size, shape, color, type, and location of the injury.

- ◆ Photographs of visible external injuries, as long as:
 - The photograph was taken by a credible person who has maintained possession;
 - You can document the date the photograph was taken through information obtained from a credible person;
 - The identity of the subject of the photograph can be determined; and
 - The photograph adequately depicts the injury.
- ◆ Diagnosis or verification by a medical practitioner of the presence of an external or internal injury or an injury which is not readily visible, including but not limited to:
 - Brain damage
 - Damage from intentional poisoning
 - Dislocations
 - Eye injuries
 - Evidence of smothering
 - Fractures
 - Internal abdominal or chest injuries
 - Other central nervous system damage
 - Ruptured ear drum
 - Shaken or slammed baby syndrome
 - Sprains
 - Subdural hemorrhage or hematoma

Information from the medical practitioner should include a complete description of the injury and, if possible, the practitioner's best professional judgment of the cause of the injury.

For fractures and some other injuries, obtain the practitioner's estimation of the amount of force necessary to cause the injury, if possible.

- ◆ Observation of or verification by a credible person of the presence of scar tissue or other change in bodily tissue that results from healing of an injury.

- ◆ X-rays or other diagnostic tests which verify the presence of injury, if:
 - The tests were taken by a competent professional who has maintained possession,
 - A credible person can document the date of tests, and
 - You can document that tests were taken on the child who is the subject of the assessment.

Factor 4: The injury is **nonaccidental** or the history given is at **variance** with the injury.

Nonaccidental means that a reasonable and prudent person would have been able to foresee that injury to a child might result from the caretaker's acts.

Note: When minor injuries (red marks, faint bruising, etc.) occur because of the acts or omissions of a caretaker, consider whether the minor injuries could have been accidental in nature and not readily foreseen. If minor injuries occur, consider consulting with a physician to determine whether these minor injuries would have required a healing process.

To conclude that the injury is **at variance** with the history given for the injury, you must have credible evidence that the injury occurred in a manner which is not physically possible or which is incongruous with the injury itself.

Factor 5: The injury resulted from the **acts or omissions** of the responsible caretaker.

Examples of credible evidence include:

- ◆ Admission by caretaker that the caretaker's act or omission resulted in the injury or could have resulted in the injury.
- ◆ Visual observation by a credible witness of acts or omissions of the responsible caretaker that (as the witness believes) resulted in the injury.
- ◆ Establishment through circumstantial information that the injuries occurred during the time that the caretaker was in actual control of the child and that injuries could not have occurred in the absence of abuse.

Physical Abuse by Omission

Physical abuse by omission may also be a valid determination. In order to establish physical abuse by omission, there must be a confirmation that:

- ◆ Physical abuse (or physical assault, if the assailant was not a caretaker) was committed against a child.
- ◆ The abuse or assault took place after the child's caretaker knew or should reasonably have known that the child was in danger of being physically abused by this person.
- ◆ The caretaker continued to allow the person access to the child or failed to take reasonable action to protect the child from being abused.

Injury During Discipline or Restraint

In no case is the statement that an injury occurred in the course of discipline or restraint a sufficient reason, in and of itself, for determining that physical abuse has occurred.

Restraint may be necessary when other methods fail to control a child's violent, aggressive, or destructive behavior. Restraint may be determined to be physical abuse when applied with cruelty or excessive force, or when used in a situation in which the child's behavior does not warrant such measures.

For example, use of physical restraint may be considered a form of physical discipline. A child may receive an injury while a caretaker is attempting to restrain the child from hurting himself or others or from destroying property. If this discipline technique was commensurate with the child's behavior and warranted under the circumstances, then the incidental injury is not considered physical abuse.

You must document and analyze:

- ◆ The behavior of the child that prompted the caretaker to use physical restraint.
- ◆ The type of restraint and degree of force that was used.
- ◆ Whether agency guidelines or professional advice sanctioned the type of restraint.
- ◆ Other types of nonphysical discipline that could have been used instead.

- ◆ The immediate outcome of the restraint tactic.

A caretaker is attempting to spank a child's buttocks with a hand. Although no injury has occurred in previous spankings, the child in this instance moves in such a way as to lose balance. This causes both the child and the caretaker to fall onto a table, resulting in injury to the child.

Even though it occurred while the caretaker was using physical discipline, the injury could under these circumstances be considered accidental.

- ◆ Whether both the child and the caretaker have basically the same perceptions as to the severity of past physical discipline and the circumstances of the present injury.

The caretaker states there was no previous injury, but the child says that there have been bruises in the past from spankings. The child says the caretaker pushed the child into the table, but the caretaker says they both fell.

Under these circumstances, if the child is considered more credible, the injury might more likely be inflicted than accidental, and an abuse finding is probably more appropriate.

- ◆ Whether the caretaker was disciplining with a higher degree of anger, energy or force than that used in previous discipline, or than that which a reasonable and prudent person would use. (This does not apply directly in the case above, but should be considered when analyzing the child's reaction to the discipline tactic.)
- ◆ Whether a reasonable and prudent person would have:
 - Been able to foresee in the child's speech or behavior that the child might act in such a way as to lead to injury, and then
 - Been able to change disciplinary tactics soon enough to avoid causing injury.

For example, knowing that a child was so emotionally distraught as to be on the verge of being out of control, a reasonable and prudent person would probably not attempt a physical intervention, unless there was no other alternative to prevent injury to the child or others.

- ◆ Whether the child was physically assaulting the caretaker, and the caretaker had no alternative but to respond physically in self-defense.

Injury During Self-Defense

People responsible for the care of child may exercise such reasonable force as may be, or appear at the time to be, necessary to protect themselves from bodily injury. Self-defense that results in injury to a child is not physical abuse if it can be established that the caretaker had no available alternative response to stop the child's assault.

However, in no case is the statement that an injury occurred in the course of self-defense a sufficient reason, in and of itself, for a finding that physical abuse has not occurred. Self-defense is tested by whether the force used to repel the attack was reasonable. The privilege is lost if the force becomes excessive. Abusive language is not sufficient to justify an assault and battery.

Topic 9: Confirming Mental Injury

Link to [Policy](#)

In order to establish that mental injury has occurred as a result of the actions of caretakers, there must be solid evidence in the form of a diagnosis by a licensed clinical professional as well as clear evidence of substantial impairment of child functioning.

For allegations of mental injury, gather and document credible evidence that the following factors are present:

- Factor 1:** The victim is a **child**.
- Factor 2:** The person responsible for the abuse was a **caretaker** for the child at the time of the abuse.
- Factor 3:** There is **observable and substantial impairment** in the child's ability to function within the normal range of performance and behavior.

Examples of credible evidence of impairment include:

- ◆ A verbal or written statement from a physician or qualified mental health professional that the child has suffered an "observable and substantial impairment." (See the definition of "[mental health professional](#).")
- ◆ A medical or psychological diagnosis that describes a condition that a reasonable and prudent person would be able to observe and would consider to be a substantial impairment.
- ◆ Observation by a credible person involved with the child that documents behavior that would constitute an "observable and substantial impairment."

- Factor 4:** This impairment is **diagnosed and confirmed** by a licensed physician or qualified mental health professional.

Examples of credible evidence include:

- ◆ A verbal or written statement from a physician or qualified mental health professional that the child has suffered an "observable and substantial impairment."
- ◆ A documented medical or psychological diagnosis that describes a condition that a reasonable and prudent person would be able to observe and would consider to be a substantial impairment.

This impairment was the result of the **acts or omissions** of the child's caretaker.

Examples of credible evidence include:

- ◆ A verbal or written statement from a physician or qualified mental health professional that the child's impairment is the result of the acts or omissions of the child's caretakers.
- ◆ A statement from a credible person that the child's impairment could not have happened except for the acts or omissions of the child's caretakers.

Topic 10: Confirming Sexual Abuse

Link to [Policy](#)

Child sexual abuse is defined in the Juvenile Code in terms of the offenses listed as sexual abuse in the Criminal Code. "Sexual abuse" is any sexual offense committed to or with a child as a result of the acts or omissions of a caretaker.

Absent any information to the contrary in the factors under each sexual offense listed below, assume that for child abuse purposes, the definition of "child" is a person under the age of 18.

Iowa law establishes 14 subcategories of sexual abuse. If more than one sexual offense has occurred in a single incident, consider the most serious offense that fits the factors outlined below. There is no need for multiple determinations from a single offense. Example:

It can be reasonably inferred that fondling of a child under age 12 occurred at the same time as sexual intercourse, but it is not necessary to make another determination in addition to second-degree sexual abuse for that incident.

However, there may be incidents of fondling or other sexual behavior occurring at another time that can and should be addressed in addition to the determination for the incident of intercourse.

Sexual abuse by omission may also be a valid determination. In these situations, it must be established that:

- ◆ A sexual offense was committed to or with a child.
- ◆ The offense occurred after the child's caretaker knew or should reasonably have known that the offender was a past perpetrator of child sexual abuse or had a sexual proclivity for children.
- ◆ The caretaker continued to allow that offender access to the child or failed to take reasonable action to protect the child from the offender.
- ◆ Consensual sex between a noncaretaker and a child 16 years of age or older: If a child aged 16 or older is able to give consent and the other person is an adult and not a caretaker, the circumstance does not meet criteria for a child abuse sexual assessment ("Able to give consent" involves Iowa Code sections [709.1](#) and [709.1A](#).)

For allegations of sexual abuse, gather and document credible evidence that the following factors are present for the relevant subcategory of sexual abuse:

Sexual Abuse in the First Degree

Factor 1: The victim is a **child**.

Factor 2: The person responsible for the abuse was a **caretaker** for the child at the time of the abuse.

Factor 3: The caretaker committed a **sex act** with or to the child. Credible evidence may include:

- ◆ Information provided by a credible person (the victim, the caretaker, or a person who observed the sex act). Information obtained should include a precise description of the type of activity in which the participants engaged.
- ◆ Diagnosis or verification by a competent medical practitioner of the presence of genital injuries or a condition or disease that could not have occurred in the absence of a sex act.
- ◆ Verification by a competent professional of the presence of sperm in the child's anus, mouth, vagina, or genital area.
- ◆ Verification by a competent professional of the presence of body tissue of the caretaker on the child or body tissue of the child on the caretaker which could not have occurred in absence of a sex act.

Factor 4: A person other than the person responsible for the abuse suffers a **serious injury** as defined in Iowa Code section [702.18](#).

Note: For use in this factor only, "serious injury" means any of the following:

- ◆ Disabling mental illness.
- ◆ Bodily injury that creates a substantial risk of death, causes serious permanent disfigurement, or causes protracted loss or impairment of the function of any bodily member or organ.
- ◆ Any injury to a child that requires surgical repair and necessitates the administration of general anesthesia.

Serious injuries include, but are not limited to, skull fractures, rib fractures, and metaphyseal fractures of the long bones of children under the age of four years.

Credible evidence may include:

- ◆ Evidence from a credible person that serious injury occurred.
- ◆ Evidence from a credible person that serious injury occurred to a person other than the caretaker during the commission of the sex act.

Sexual Abuse in the Second Degree

Factor 1: The victim is a **child**.

Factor 2: The person responsible for the abuse was a **caretaker** for the child at the time of the alleged abuse.

Factor 3: The caretaker committed a **sex act** with or to the child. Examples of credible evidence include:

- ◆ Information provided by a credible person (the victim, the caretaker, or a witness who observed the sex act). The information obtained should include a precise description of the type of activity in which the victim and the person responsible for the abuse were engaged.
- ◆ Diagnosis or verification by a competent medical practitioner of the presence of genital injuries or a condition or disease that could not have occurred in the absence of the sex act.
- ◆ Verification by a competent professional of the presence of sperm in the child's anus, mouth, vagina, or genital area.
- ◆ Verification by a competent professional of the presence of body tissue of the caretaker or body tissue of the child on the caretaker which could not have occurred in absence of a sex act.

Factor 4: One of the following conditions exists:

- ◆ The child is **under age 12**, OR
- ◆ The child is suffering from a **mental defect or incapacity** that precludes giving consent, or the child lacks mental capacity to know the right or wrong of conduct in sexual matters, OR
- ◆ The sex act was **committed by force** or against the child's will, and the caretaker was aided or abetted by one or more people, OR
- ◆ The caretaker **displayed a dangerous weapon** in a threatening manner, OR
- ◆ The caretaker **used or threatened to use force** creating a substantial risk of death or serious injury.

Examples of credible evidence include:

- ◆ Credible statement of a credible person (the victim or the caretaker) that one of the above circumstances happened in the course of the sex act.
- ◆ Statement of a credible witness (including people who aided and abetted the caretaker) who can verify that one of the above circumstances happened in the course of the sex act.
- ◆ Physical evidence of the presence of a dangerous weapon, use of force, or presence of one or more people who aided or abetted the caretaker.

Sexual Abuse in the Third Degree

Factor 1: The victim is a **child**.

Factor 2: The person responsible for the abuse was a **caretaker** for the child at the time of the abuse.

- Factor 3:** The caretaker committed a **sex act** with or to the child. Credible evidence may include:
- ◆ Information provided by a credible person (the victim, the caretaker, or a witness who observed the sex act). The information obtained should include a precise description of the type of activity in which the participants engaged.
 - ◆ Diagnosis or verification by a competent medical practitioner of the presence of genital injuries or a condition or disease that could not have occurred in the absence of a sex act.
 - ◆ Verification by a competent professional of the presence of sperm in the child's anus, mouth, vagina, or genital area.
 - ◆ Verification by a competent professional of the presence of body tissue of the caretaker on the child or of body tissue of the child on the caretaker which could not have occurred in absence of a sex act.

- Factor 4:** One of the following conditions must be present:
- ◆ The sex act was done by force or against the will of the child; or
 - ◆ The sex act was done while the child was under the influence of a controlled substance (e.g., flunitrazepam) that prevented the child from giving consent and the caretaker knew or should have known that the child was under the influence of the controlled substance; or
 - ◆ The sex act was done while the child was mentally incapacitated (temporarily unable to control conduct due to the influence of a narcotic, anesthetic, or intoxicating substance); or
 - ◆ The sex act was done while the child was physically incapacitated (unconscious, asleep, or otherwise physically limited); or
 - ◆ The sex act was done while the child was physically helpless (meaning the child has a bodily impairment or handicap that substantially limits the ability to resist or flee); or

- ◆ The caretaker and the victim are not cohabiting as husband and wife and either:
 - The child is 12 or 13 years old; or
 - The child is 14 or 15 years old, and any of the following are true:
 - The child and caretaker are members of the same household, or
 - The child and caretaker are related to each other by blood or affinity to the fourth degree, or
 - The caretaker is in a position of authority over the child and used that authority to coerce the child to submit, or
 - The caretaker is four or more years older than the child, or
 - The child is suffering from a mental defect or incapacity which precludes giving consent.

Credible evidence may include the following:

- ◆ statements of the victim, the caretaker, or the victim's parents.
- ◆ Documentation of age from the birth certificate or other legal record of the child and of the caretaker.
- ◆ Verification by a credible person that the child and the caretaker were living in the same household at the time of the alleged abuse.
- ◆ Documentation of the blood or affinity relationship between the child and the caretaker.

NOTE: If the child is under age 12, see [Sexual Abuse in the Second Degree](#).

Detention in a Brothel

Factor 1: The victim is a **child**.

Factor 2: The person responsible for the abuse was a **caretaker** for the child at the time of the abuse.

Factor 3: The **intent** of the person responsible for the abuse was to engage the victim in prostitution. Examples of credible evidence include:

- ◆ Statements of a credible person (the child, the caretaker, or a witness).
- ◆ Circumstantial evidence which indicates the intent of the person responsible for the abuse to engage the victim in prostitution.

Factor 4: The person responsible for the abuse did **either of the following**:

- ◆ Enticed a nonprostitute child to become an inmate of a brothel so as to engage the child in prostitution, or
- ◆ Detained the child in a brothel against the child's will so as to engage the child in prostitution.

Credible evidence may include documentation that the child was found in a structure meeting the definition of "brothel." It is not necessary to show that the child was detained against the child's will if the person responsible for the abuse was the child's caretaker.

Lascivious Acts With a Child

Factor 1: The victim is a **child**.

Factor 2: The person responsible for the abuse was a **caretaker** for the child at the time of the abuse.

Factor 3: The **caretaker is age 18** or older. Credible evidence may include documentation of the person's age through family, school, or other official records or identification.

Factor 4: The caretaker has done **one of the following acts:**

- ◆ Fondled or touched the victim's genitals or pubes, OR
- ◆ Permitted or caused the victim to fondle or touch the genitals or pubes of the caretaker, OR
- ◆ Solicited the victim to engage in a sex act, OR
- ◆ Inflicted pain or discomfort on the victim or has allowed the victim to inflict pain or discomfort on the caretaker (for the purpose of arousing or satisfying sexual desires of either the caretaker or the victim).

Credible evidence may include statements of a credible person (the child, the caretaker, or a witness) that at least one of the above did occur between the child and the caretaker.

Factor 5: **Either** of the following:

- ◆ The intent of the caretaker in the course of performing these acts with the child was to arouse or satisfy the sexual desires of one or both of them; OR
- ◆ The caretaker or the child was sexually aroused.

Examples of credible evidence include:

- ◆ Statements of a credible person (the child, the caretaker, or a witness) that the acts were performed with sexual intent.
- ◆ Physical evidence that indicates that sexual arousal was present, such as the presence of semen, nude photographs, or letters describing the sexual feelings of the caretaker or the victim.

Factor 6: The caretaker and the victim are not **husband and wife**. Credible evidence may include statements of the victim, the caretaker, or the victim's parents.

Indecent Exposure

- Factor 1:** The victim is a **child**.
- Factor 2:** The person responsible for the abuse was a **caretaker** for the child at the time of the abuse.
- Factor 3:** The **intent** of the person responsible for the abuse was to arouse or satisfy sexual desires of the person responsible or the victim.
- Factor 4:** The person responsible for the abuse knew or should have known the **act was offensive** to the viewer.

Examples of credible evidence include statements of a credible person (the child, the caretaker, or a witness) which indicate that:

- ◆ The child was offended, or
- ◆ The caretaker for the abuse behaved in such a way that any reasonable and prudent person would be offended.

Factor 5: **One of the following acts** occurred:

- ◆ The caretaker has exposed his or her pubes or genitals to the victim, OR
- ◆ The caretaker has committed a sex act in the presence of or view of a third person. (Note that for child abuse purposes, the "third person" would most likely be the child victim, unless the sex act was with the child in front of someone else.)

Credible evidence may include statements of a credible person (the child, the caretaker, or a witness) that the caretaker did:

- ◆ Expose pubes or genitals to the child or
- ◆ Commit a sex act with the child in the presence or view of another person or with another person in the presence or view of the child.

Assault With Intent to Commit Sexual Abuse

- Factor 1:** The victim is a **child**.
- Factor 2:** The person responsible for the abuse was a **caretaker** for the child at the time of the abuse.
- Factor 3:** The **intent** of the person responsible for the abuse was to commit sexual abuse. Examples of credible evidence include:
- ◆ Statements of a credible person (the child, the caretaker, or witnesses).
 - ◆ Circumstantial evidence which indicates the intent of the person to commit sexual abuse.
- Factor 4:** **One of the following acts** occurred without justification (that is, in the absence of noncriminal sport or social activity):
- ◆ Any act which is intended to cause pain or injury to another, or which is intended to result in physical contact which will be insulting or offensive to another, coupled with the apparent ability to execute the act; OR
 - ◆ Any act which is intended to place another in fear of immediate physical contact which will be painful, injurious, insulting, or offensive, coupled with the apparent ability to execute the act; OR
 - ◆ The person responsible for the abuse represented to the victim that he or she was in immediate possession or control of a firearm, displayed a firearm in a threatening manner, or was armed with a firearm; OR
 - ◆ The person responsible for the abuse displayed any dangerous weapon in a threatening manner.

Credible evidence may include:

- ◆ Statements of a credible person (the child, the caretaker, or a witness), which indicate that the caretaker intended to cause pain or injury, or commit insulting or offensive physical contact.
- ◆ Circumstantial evidence that indicates that the caretaker intended to cause pain or injury or to commit insulting or offensive physical contact.
- ◆ Documentation that the behavior did not occur as part of a non-criminal sport or social activity (meaning the behavior was not an unavoidable or accidental contact with no sexual connotations).
- ◆ Documentation from statements of a credible person (the child, the caretaker, or a witness) that the child did suffer pain, injury, or insulting or offensive physical contact (although if this is true, a more serious type of sexual abuse may have occurred) or was in fear of such consequences.
- ◆ Statements of child, the caretaker, a physician, or a witness that the person responsible for the abuse did have the ability to execute the intended assault.
- ◆ Documentation of presence of a firearm or other dangerous weapon that was displayed in a threatening manner at the time of the incident through statements of the victim, the person responsible for the abuse, or witnesses.

Indecent Contact With a Child

Factor 1: The victim is a **child**.

Factor 2: The person responsible for the abuse was a **caretaker** for the child at the time of the abuse.

Factor 3: The **person responsible** for the abuse is:

- ◆ Aged 18 or older, OR
- ◆ Aged 16 or 17 AND committed any of the acts indicated in Factor 5 with a child more than five years younger.

Factor 4: The intent of the person responsible for the abuse was to **arouse or satisfy the sexual desires** of the person responsible or of the victim.

Factor 5: One of the following acts occurred:

- ◆ The person responsible for the abuse has fondled or touched the inner thigh, groin, buttock, anus, or breast of the victim, or clothing covering the same body parts, OR
- ◆ The person responsible for the abuse has permitted or caused the victim to fondle or touch the person's genitals, pubes, inner thigh, groin, buttock, anus or breast, OR
- ◆ The person responsible for the abuse has solicited the victim to allow that person to inflict pain or discomfort on the victim, OR
- ◆ The person responsible for the abuse has solicited the victim to inflict pain or discomfort on the person.

Examples of credible evidence include:

- ◆ Statement of a credible person (the victim, the caretaker, or a witness) which indicate that:
 - The caretaker has fondled or touched the child in those ways or
 - The child has touched the caretaker in those ways.
- ◆ Medical documentation of fondling of genitalia which indicate that:
 - The caretaker has fondled or touched the child in those ways, or
 - The child has touched the caretaker in those ways.
- ◆ Statement of a credible person (the victim, the caretaker, or a witness) that the caretaker solicited the victim to:
 - Allow infliction of pain or discomfort on the victim or
 - Inflict pain or discomfort on the caretaker.

Factor 6: The person responsible for the abuse and the victim are **not husband and wife**. Credible evidence may include statements of the victim, the person responsible for the abuse, or the victim's parents.

Lascivious Conduct With a Minor

- Factor 1:** The victim is a **child**.
- Factor 2:** The person responsible for the abuse was a **caretaker** for the child at the time of the abuse.
- Factor 3:** **The caretaker is aged 18** or older. Credible evidence may include documentation of the person's age through family, school, or other official records or identification.
- Factor 4:** The caretaker used force, persuasion, or coercion to have the **victim disrobe or partially disrobe** for the purpose of **arousing or satisfying the sexual desires** of either of them.

Examples of credible evidence include:

- ◆ Statement of a credible person (the victim, the caretaker, or a witness) which indicates that the caretaker did attempt to have the victim disrobe or partially disrobe or took advantage of the victim's disrobed or partially disrobed state.
 - ◆ Medical documentation of indications that the victim was forced.
 - ◆ Statement of a credible person (the victim, the caretaker, or a witness) that the reason the child was forced, persuaded, or coerced to disrobe or partially disrobe was to arouse or satisfy the sexual desires of either the child or the caretaker. That is, either:
 - There was no other legitimate reason for the child to disrobe or for the caretaker to view the child in a disrobed or partially disrobed state, or
 - The caretaker or the child admitted that this action was for the purpose of sexual arousal.
- Factor 5:** The caretaker and the victim are **not husband and wife**. Credible evidence may include statements of the victim, the caretaker, or the victim's parents.

Sexual Exploitation by a Counselor, Therapist or School Employee

Factor 1: The victim is a **child**.

Factor 2: The person responsible for the abuse was a **caretaker** for the child at the time of the alleged abuse.

Factor 3: The person responsible for the abuse:

- ◆ Is currently a **counselor or therapist** (see the definition of "[counselor or therapist](#)") **providing mental health services** to the child, or
- ◆ Has been the child's counselor or therapist within the past year, or
- ◆ Is a school employee, meaning a "practitioner" as defined in Iowa Code section [272.1](#).

Note: A "student" is a child who is currently enrolled in or attending a public or nonpublic elementary or secondary school, or who was a attending school within 30 days of the sexual exploitation.

Credible evidence may include statements that the child and the person allegedly responsible for the abuse have a counseling or therapeutic relationship now or have had such a relationship within the past year. These statements could be from:

- ◆ The child,
- ◆ The child's caretakers,
- ◆ The child's social worker, or
- ◆ Administrative staff at the facility where the child lives or receives counseling or therapy (or did so in the past).

Factor 4: **Any** of the following occurred:

- ◆ A pattern or practice of sexual conduct between the child and the counselor, therapist, or school employee, OR
- ◆ A scheme on the part of the counselor, therapist, or school employee to engage in sexual conduct with the child.

For the purpose of this factor, "sexual conduct" includes:

- ◆ Kissing.
- ◆ Touching of the clothed or unclothed inner thigh, breast, groin, buttock, anus, pubes, or genitals.
- ◆ A sex act.

Note: This is the only type of sexual abuse in which a person may receive a conclusion of confirmed child abuse for kissing or attempting to seduce a child.

Although such behavior may not be considered a sexual offense under other circumstances, it takes on overtones that are more serious in a therapeutic or student relationship because of its exploitative and potentially damaging aspects. This is true even if no sex act ever happens, and even if the child victim is not frightened or "offended" by the behavior.

Examples of credible evidence include:

- ◆ Statements of a credible person (the child, the counselor, therapist, school employee or a witness) that at least one of the above did occur between the child and the counselor, therapist or school employee.
- ◆ Statements of a credible person (the child, the counselor, therapist, or school employee, or a witness) that the counselor, therapist, or school employee had been planning with the child to engage in sexual conduct.
- ◆ Written statements of the child or the counselor, therapist or school employee in the form of notes or letters to each other or to other people which would lead a reasonable person to infer that sexual conduct between the two had happened or was being planned.

- Factor 5:** The **intent** of the counselor, therapist, or school employee was to arouse or satisfy the sexual desires of the child or of the counselor, therapist, or school employee. Credible evidence may include:
- ◆ Statements of a credible person (the child, the counselor, therapist, or school employee, or a witness), or circumstantial evidence indicating that the actions of the counselor, therapist, or school employee were performed with the child for the purpose of arousing or satisfying the sexual desires of either of them.
 - ◆ Physical evidence indicating that the counselor, therapist or school employee was sexually aroused during contact with the child, such as:
 - Suggestive photographs or other depictions of the child.
 - Letters describing the sexual feelings of the counselor, therapist, or school employee toward the child.
 - ◆ Observation by people having knowledge of the therapeutic relationship or student relationship of the appearance, behavior, or statements of the counselor, therapist or school employee which indicate a sexual rather than a professional interest in the child.

Such people could be other children in treatment, other students, coworkers of the person allegedly responsible for the abuse, the child's family, etc.

- Factor 6:** The conduct of the counselor, therapist, or school employee:
- ◆ Was **not part of a necessary examination or treatment** provided to the child by the counselor or therapist while acting within the scope of the practice or employment in which the counselor or therapist was engaged; or
 - ◆ Was **not necessary** in the performance of the school employee's duties while acting within the scope of employment.

Credible evidence includes statements of a credible person (the child, the counselor or therapist, witnesses, or administrative staff at the facility) that the sexual conduct was **not**:

- ◆ Part of a legitimate physical or sexual examination or treatment for a physical or sexual problem or
- ◆ Sanctioned by the facility and approved by the child's parent, guardian, or custodian.

Sexual Misconduct with Juveniles

Factor 1: The victim is a **child**.

Factor 2: The person responsible for the abuse was a **caretaker** for the child at the time of the alleged abuse.

Factor 3: The person responsible for the abuse is an officer, employee, contractor, vendor, volunteer, or agent of a **juvenile placement facility**.

Note: For use in this section only, "juvenile placement facility" means any of the following:

- ◆ A child foster care facility.
- ◆ A juvenile detention or juvenile shelter care home.
- ◆ A psychiatric medical institution for children.
- ◆ A substance abuse facility as defined in Iowa Code section [125.2](#).
- ◆ An institution controlled by the Department of Human Services (or another facility not attached to the campus of the main institution, as program developments require):
 - Iowa State Training School (Eldora)
 - Iowa Juvenile Home (Toledo)
 - Glenwood and Woodward Resource Centers
 - Cherokee, Clarinda, Independence, and Mount Pleasant Mental Institutes

Factor 4: The child is **placed** at the juvenile placement facility.

- Factor 5:** The caretaker committed a **sex act** with or to the child. Credible evidence may include:
- ◆ Information provided by a credible person (the victim, the caretaker, or a witness who observed the sex act) that includes a precise description of the type of activity in which the victim and the person responsible for the abuse were engaged.
 - ◆ Diagnosis or verification by a competent medical practitioner of the presence of genital injuries or a condition or disease that could not have occurred in the absence of the sex act.
 - ◆ Verification by a competent professional of the presence of sperm in the child's anus, mouth, vagina, or genital area.
 - ◆ Verification by a competent professional of the presence of body tissue of the child or the caretaker that could not have occurred in the absence of the sex act.

Incest

- Factor 1:** The victim is a **child**.
- Factor 2:** The person responsible for the abuse was a **caretaker** for the child at the time of the abuse.
- Factor 3:** The caretaker committed a **sexual act** with or to the child. Credible evidence may include:
- ◆ Information provided by a credible victim or person responsible for the abuse, including a precise description of the activity that occurred.
 - ◆ Observation of the sex act by a credible person, including a precise description of the activity that occurred.
 - ◆ Diagnosis or verification by a competent medical practitioner of the presence of genital injuries, condition, or disease that could not have occurred in the absence of a sex act.
 - ◆ Verification by a competent professional of the presence of sperm in the child's anus, mouth, vagina, or genital area.
 - ◆ Verification by a competent professional of the presence of body tissue of the caretaker, or body tissue of the child on the caretaker which could not have occurred in absence of a sex act.

Factor 4: The person responsible for the abuse was aged 14 or older at the time of the offense.

Credible evidence may include documentation of the person's age through family, school or other official records or identification.

Factor 5: The person responsible for the abuse knew that the victim was related, legitimately or illegitimately, as an ancestor, descendant, brother or sister of the whole or half blood, aunt, uncle, niece, or nephew.

Credible evidence would include statements of a credible person (the child, the caretaker, or family members, or others who would have knowledge or documentation of the family history).

Sexual Exploitation of a Minor

Factor 1: The victim is a **child**.

Factor 2: The person responsible for the abuse was a **caretaker** for the child at the time of the abuse.

Factor 3: The **intent** of the caretaker was to employ, use, persuade, induce, entice, coerce, solicit, knowingly permit, or otherwise cause or attempt to cause a child to engage in a prohibited sexual act or in the simulation of a prohibited sexual act. (See the definition of "[prohibited sexual act](#).")

Factor 4: The caretaker allowed the child to engage in a **prohibited sexual act or simulated act**.

Factor 5: The caretaker intended, knew or had reason to know that the sexual act or simulated act may be or was being **photographed, filmed, or otherwise preserved** in a negative, slide, book, magazine, or other print, electronic or visual medium.

Credible evidence may include:

- ◆ Statements of the victim, person allegedly responsible for the abuse or witness that indicate that the person allegedly responsible for the abuse permitted the act and knew or should have known that it may be photographed or was being photographed or otherwise preserved.
- ◆ Photographic or other physical evidence of the sexual act.

Invasion of Privacy - Nudity

Factor 1: The victim is a **child**.

Factor 2: The person responsible for the abuse was a **caretaker** for the child at the time of the abuse.

Factor 3: The person knowingly views, photographs or films a child for the purpose of arousing or gratifying the sexual desire of any person and all the following apply:

- ◆ The child does not have knowledge about and does not consent or is unable to consent to being viewed, photographed, or filmed.
- ◆ The child is in a state of full or partial nudity.
- ◆ The child has a reasonable expectation of privacy while in a state of full or partial nudity.

As used in this section:

- ◆ "Full or partial nudity means the showing of any part of the human genitals or pubic area or buttocks, or any part of the nipple of the breast of a female, with less than fully opaque covering.
- ◆ "Photographs or films" means the making of any photograph, motion picture film, videotape, or any other recording or transmission of the image of a child.

Note: A Person who violates Iowa Code section [709.211](#) commits a serious misdemeanor.

Topic 11: Confirming Denial of Critical Care

Link to [Policy](#)

It is important to separate issues of poverty from neglect when assessing allegations of denial of critical care. When the caregiver is financially unable to provide for the child's needs, the provision of or referral to community resources and services may resolve the situation.

Denial of critical care consists of several categories that address the basic needs of a child and the acts or omissions of the caretaker that deny that child these basic needs.

The subcategories of denial of critical care follow, with factors that must be present for a finding that denial of critical care has occurred for each category. For allegations of denial of critical care, gather and document credible evidence that the following factors are present for the subcategory of denial of critical care.

When there is more than one category that applies to an incident of denial of critical care, make a finding for each.

Failure to Provide Adequate Food

Factor 1: The victim is a **child**.

Factor 2: The person responsible for the abuse was a **caretaker** for the child at the time of the abuse.

Factor 3: The caretaker has **failed to provide for adequate food** and nutrition. Examples of credible evidence include:

- ◆ A statement from a credible person regarding the amount, frequency of provision, or nutritional content of the child's food intake, or
- ◆ Evidence that the child has been ingesting spoiled or otherwise inedible or dangerous food items.

Factor 4: The child was placed in **danger of suffering injury or death**.

An example of credible evidence is a diagnosis by a medical practitioner that the child has been placed in danger of suffering injury or death due to nutritional deficiencies in the child's diet or due to ingestion of potentially dangerous food items.

Factor 5: The caretaker was **financially able** to provide for the child's critical care needs, or refused to do so when offered financial and other reasonable means.

Examples of credible evidence include documentation of income or resources made available to the caretaker when the child's critical care needs were discovered.

Failure to Provide Adequate Shelter

Factor 1: The victim is a **child**.

Factor 2: The person responsible for the abuse was a **caretaker** for the child at the time of the abuse.

Factor 3: The caretaker has **failed to provide for adequate shelter**.
Examples of credible evidence include:

- ◆ Statements regarding:
 - Inadequate provisions for sanitation or physical safety of children,
 - Lack of necessary utilities for normal household activities or protection from the elements, or
 - Environmental hazards present in the home.
- ◆ Observation by the protective worker or another credible person that conditions existing at the family's place of residence are such that they would have to have been accumulating over time, rather than existing due to a crisis or disaster situation.

Factor 4: The child was placed in **danger of suffering injury or death**.
Examples of credible evidence include:

- ◆ Statement by a medical practitioner that:
 - The child as placed in danger of suffering injury or death as a result of exposure to hazardous or unsanitary conditions present in the physical environment where the child is living,
OR
 - These conditions are likely to create such a condition or injury.

- ◆ Observation and documentation by photograph or videotape of conditions present in the physical environment where the child is living that a reasonable and prudent person would (or should) know would be hazardous to the child's health or physical safety.
- ◆ Statement from the county department of sanitation or the fire marshal that the residence has been declared unfit for human habitation.
- ◆ Documentation of weather conditions that created a hazardous environment for the child, given the inadequacies of the child's shelter, such as a family living in below-zero weather with no heat.

Factor 5: The caretaker was **financially able** to provide for the child's critical care needs or refused to do so when offered financial and other reasonable means.

Credible evidence may include documentation of income or resources made available to the caretaker when the child's critical care needs were discovered.

Note: Consider the condition of the shelter that endangers the child in light of the child's age, medical condition, mental and physical maturity, and functioning level.

Failure to Provide Adequate Clothing

Factor 1: The victim is a **child**.

Factor 2: The person responsible for the abuse was a **caretaker** for the child at the time of the abuse.

Factor 3: The caretaker has **failed to provide for adequate clothing**.
Examples of credible evidence include:

- ◆ Observation and documentation by a credible person of the child's manner of dress indicating that the clothing provided was not adequate to meet the child's needs.
- ◆ Documentation of weather records that confirm weather conditions from which the child's manner of dress would not protect the child adequately.

Factor 4: The child was placed in **danger of suffering injury or death**.

Credible evidence may include a statement by a medical practitioner that the child was placed in danger of suffering injury or death, due to the caretaker's failure to provide adequate clothing.

Factor 5: The caretaker was **financially able** to provide for the child's critical care needs, or refused to do so when offered financial and other reasonable means.

Credible evidence may include documentation of income or resources made available to the caretaker when the child's critical care needs were discovered.

Failure to Provide Adequate Health Care

Factor 1: The victim is a **child**.

Factor 2: The person responsible for the abuse was a **caretaker** for the child at the time of the abuse.

Factor 3: The caretaker has **failed to provide for adequate health care**.
Credible evidence may include:

- ◆ Statement by a medical practitioner that the recommendation was made for treatment of the child and that the caretaker failed to follow through with this treatment (unless the caretaker was following a contradictory recommendation from another practitioner at the time).
- ◆ Statement that the child had an ongoing (not emergency) condition or illness which a reasonable and prudent person would have known, or should have known, could be remedied by treatment, which was not provided, and the child's condition worsened.

Factor 4: The child was placed in **danger of suffering injury or death**.

Credible evidence may include a statement by a medical practitioner that the child was placed in danger of suffering injury or death, due to the caretaker's failure to provide or arrange for health care for the child.

Factor 5: The failure to provide medical treatment is **not based upon the religious beliefs** of the parent or guardian. Credible evidence may include:

- ◆ Statement from the parent or guardian or other knowledgeable person that the parent or guardian did not follow religious beliefs or teachings or advice from a spiritual advisor in making the decision not to seek medical treatment for the child.
- ◆ Statements of people who are aware that the parent or guardian has never been a follower of the religious belief before the onset of the child's illness or condition.
- ◆ Statement of the parent or guardian's pastor, priest, rabbi, or other spiritual advisor, regarding this person's knowledge or approval of the religious beliefs of the parent or guardian regarding provision of traditional medical treatment for physical conditions or illness.

(See [Withholding Medical Care Due to Religious Beliefs](#).)

Factor 6: The caretaker was **financially able** to provide for the child's critical care needs, or refused to do so when offered financial and other reasonable means.

Credible evidence may include documentation of income or resources made available to the parent or guardian when the child's critical care needs were discovered.

Failure to Provide Mental Health Care

Factor 1: The victim is a **child**.

Factor 2: The person responsible for the abuse was a **caretaker** for the child at the time of the abuse.

Factor 3: The **caretaker knew or should reasonably have known** of the child's observable and substantial impairment in the ability to function. Examples of credible evidence include:

- ◆ Documentation that the caretaker:
 - Was informed that the child suffered from an observable and substantial impairment (or a condition which a reasonable and prudent person would identify as an observable and substantial impairment) and
 - Failed to follow through on a recommendation to obtain mental health care for the problem.
- ◆ Statement of the caretaker that in spite of being made aware of the child's observable and substantial impairment, the caretaker did not seek mental health care for the child, and did not intend to do so in the future. (Document the caretaker's reasoning, if possible.)

Factor 4: The caretaker has **failed to provide for mental health care** necessary to adequately treat the observable and substantial impairment in the ability to function. Examples of credible evidence include:

- ◆ Statement from school staff or another professional showing that a recommendation for a mental health evaluation was made as a result of documentation of the child's behavior, statements, or appearance that indicated an observable and substantial impairment.
- ◆ Diagnosis from a mental health professional of a psychological condition or syndrome that would be considered by a reasonable and prudent person to be an example of observable and substantial impairment.

Factor 5: The caretaker was **financially able** to provide for the child's critical care needs, or refused to do so when offered financial and other reasonable means.

Credible evidence may include documentation of income or resources made available to the caretaker when the child's critical care needs were discovered.

Gross Failure to Meet Emotional Needs

Factor 1: The victim is a **child**.

Factor 2: The person responsible for the abuse was a **caretaker** for the child at the time of the abuse.

Factor 3: The caretaker has shown a **gross failure to meet emotional needs** necessary for normal development of the child. Examples of credible evidence include:

- ◆ Statement from a physician or mental health professional that documents a psychological or physical condition that can be shown to be a direct result of the caretaker's failure to meet the child's emotional needs.
- ◆ Observation by the child protection worker or other professional that:
 - The caretaker does not appear to be interacting with the child in an appropriately nurturing fashion; or
 - There is a significant lack of "bonding" or "attachment" between the caretaker and the child; or
 - The caretaker ignores the child; or
 - The caretaker singles the child out for verbal insults, name-calling, or other demeaning or dehumanizing treatment.

Factor 4: The caretaker knew or should reasonably have known of the child's observable and substantial impairment in the ability to function within the normal range of performance and behavior. Examples of credible evidence include:

- ◆ Statement from the caretaker or professionals that the child is developmentally delayed.
- ◆ Observation by the child protection worker or other professionals involved with the child that the child's appearance and behavior are indicative of substantial impairment (either significant emotional or physical delays), considering the child's age and apparent health.

Factor 5: The caretaker was **financially able** to provide for the child’s critical care needs, or refused to do so when offered financial and other reasonable means.

Credible evidence may include documentation of income or resources made available to the caretaker when the child’s critical care needs were discovered.

Failure to Provide Proper Supervision

“Failure to provide proper supervision” is a category that includes such actions as abandonment, child endangerment, and other forms of maltreatment that do not meet the definitions for other types of abuse.

“Failure to provide proper supervision” also includes situations when a child is harmed or is exposed to risk of harm or danger of abuse through the failure of the caretaker to protect the child from a person who is known to be abusive to children.

Note: If abuse has already occurred through the caretaker’s failure to protect the child from a known perpetrator, consider a finding of abuse by omission.

Factor 1: The victim is a **child**.

Factor 2: The person responsible for the abuse was a **caretaker** for the child at the time of the abuse.

Factor 3: The child was **directly harmed or placed at risk of harm**.
Examples of credible evidence include:

- ◆ Observation and documentation by the child protection worker or other credible person of the child’s circumstances at the time of the abuse and analysis of the inherent risk of harm or danger of the situation.
- ◆ Statements from the child, the caretaker, or other witnesses as to the circumstances of the incident and the person’s viewpoint as to whether or not the child was harmed or at risk of harm or danger.
- ◆ Statements of the child, the caretaker, or witnesses that a deadly weapon was intentionally aimed at the child or the child was threatened with a weapon.

- ◆ Law enforcement reports concerning an incident of assault, domestic violence, or other criminal act involving the child and caretaker, which document that the child was threatened with a deadly weapon.
- ◆ Statements of the child, the caretaker, or witnesses that in the course of assaulting or threatening another person's life or health, the caretaker harmed the child or placed the child at risk of harm or in danger of injury or death.
- ◆ Statements of the child, the caretaker, or witnesses that the child was involved in a domestic violence incident between the child's caretakers in which the child was forced or encouraged into the position of protecting one of the participants, exposing the child to direct harm, risk of harm, or life-threatening or health-threatening conditions.
- ◆ Law enforcement, medical, or domestic violence shelter reports concerning an incident of assault, domestic violence, or other criminal act involving the child and caretaker which document that the child was directly harmed or was placed at risk of harm or in a life-threatening or health-threatening situation due to the acts or omissions of the caretaker.
- ◆ Documentation that a child has been directly harmed or has been placed at risk of harm or in danger by being cruelly or unduly confined, either:
 - Physically, through binding, tying, or chaining;
 - Chemically, as in use of sedative medication; or
 - Indirectly, by locking a child in a room, closet, or restricted area.

Credible evidence that a child has been harmed or placed at risk of harm or in danger by confinement includes:

- ◆ Statements of the child, the caretaker, or witnesses that a child has been physically, chemically, or indirectly restrained or confined, either as a form of discipline or for punishment (not accidentally). Statements should indicate:
 - The length of the confinement or restraint.
 - The number of times the confinement or restraint occurred.
 - The reasons for the confinement or restraint.
 - The consequences to the child who was confined or restrained.

- ◆ Statement of a medical or mental health practitioner as to the condition of a child resulting from confinement or restraint imposed upon the child by a caretaker.
- ◆ Documentation that the confinement or restraint resulted in undue pain or emotional distress.
- ◆ Documentation that the confinement or restraint was unwarranted either by legal authorization or by medical sanction as a means of dealing with the child's behavior, such as:
 - Statement of the caretaker as to the caretaker's perceived authority to take such action with the child.
 - If the confinement or restraint occurred in a child care facility, a copy of the facility regulations regarding discipline and use of restraint and confinement.
- ◆ Documentation that the confinement or restraint did not include "time-outs" or other sound disciplinary techniques that might be considered to restrict a child's movement.
- ◆ Documentation that the confinement or restraint placed the child in more danger than the child would have been in if not confined or restricted.

Factor 4: The caretaker **failed to provide** the type of **supervision** that a reasonable and prudent person would exercise under similar facts and circumstances.

Examples of credible evidence include:

- ◆ Documentation of the caretaker's failure to perceive the direct harm or potential risk of harm or danger to the child.
- ◆ Documentation of the caretaker's failure to take adequate safety precautions to protect the child when the caretaker perceived direct harm or risk of harm or danger to the child.
- ◆ Documentation of the child's physical, mental, psychological, emotional, and practical abilities and limitations as these factors relate to self-protection in a given situation.
- ◆ Documentation of the statements of witnesses to the incident, and comparison of these statements with those made by the caretaker and the child.

- ◆ Statements of professionals as to whether or not the caretaker's actions to address the safety of the child were reasonable and prudent under the circumstances.

Factor 5: The caretaker was **financially able** to provide for the child's critical care needs, or refused to do so when offered financial and other reasonable means.

Credible evidence may include documentation of income or resources made available to the caretaker when the child's critical care needs were discovered.

Failure to Respond to an Infant's Life-Threatening Condition

Factor 1: The victim is an **infant**, defined as a child who:

- ◆ Is under the age of one year, or
- ◆ Is over the age of one year and
 - Has been continuously hospitalized since birth, or
 - Was born extremely prematurely, or
 - Has a long-term disability.

Factor 2: The person responsible for the abuse was a **caretaker** for the infant at the time of the abuse.

Factor 3: The caretaker has **failed to provide treatment** (including appropriate hydration, nutrition, and medication) to such an infant EXCEPT when any of the following apply:

- ◆ The child is chronically and irreversibly comatose.
- ◆ The provision of treatment would merely prolong dying.
- ◆ The provision of treatment would not be effective in ameliorating or correcting all of the child's life-threatening conditions.
- ◆ The provision of treatment would otherwise be futile in terms of the child's survival.
- ◆ The provision of treatment would be virtually futile in terms of the child's survival, and the treatment itself under such circumstances would be inhumane.

(See [Withholding Treatment to Medically Fragile Children.](#))

Examples of credible evidence include:

- ◆ Medical diagnosis of the child's disability or life-threatening condition.
- ◆ Documentation of the condition of the child at the time that the attending medical staff or caretakers made or were considering a decision to withhold treatment to the child.
- ◆ If the child has died before commencement of the assessment or dies during the assessment, a copy of the medical examiner's report on the cause of death.
- ◆ Statements of the caretakers regarding their understanding of:
 - The extent of the child's life-threatening condition.
 - The recommendations they received regarding withdrawal or withholding of life-saving water, food, or medical treatment.
 - Their decision as to what course of action should be taken for the infant's treatment.
 - How they communicated this decision to the medical personnel who were caring for the infant.

Note: Arrange medical consultation through your supervisor and the service help desk, who will request assistance from the child protective program. In no circumstance shall an assessment of an allegation of this nature be completed without consultation with medical specialists.

Factor 4: The caretaker was **financially able** to provide for the child's critical care needs, or refused to do so when offered financial and other reasonable means.

Credible evidence may include documentation of income or resources made available to the caretaker when the child's critical care needs were discovered.

Topic 12: Confirming Child Prostitution

Link to [Policy](#)

Gather and document credible evidence that the following factors are present for an allegation of child prostitution.

Factor 1: The victim is a **child**.

Factor 2: The person responsible for the abuse was a **caretaker** for the child at the time of the abuse.

Factor 3: One of the following occurred:

- ◆ The caretaker **sold** or **offered** for sale or **purchased** or **offered** for purchase the services of a child as a participant in a sex act, OR
- ◆ The caretaker **allowed, permitted, or encouraged** the child to engage in the sale or purchase or offer for sale or purchase of the child's services as a participant in a sex act.

Note: The child does not have to engage in a sex act; the offer for sale or purchase is sufficient for a finding of child abuse.

The offer of the child's services as a participant in a sex act does not have to be made by the caretaker. The caretaker may have abused the child by "allowing, permitting or encouraging" the child's exploitation as a prostitute by someone else.

The purchase or offer to purchase of the child's services as a participant in a sex act does not have to be made with money alone. There may be credible evidence of an exchange of goods or other services that fit the definition of "purchase," as long as it is understood that the exchange is in return for the child's participation in a sex act.

Credible evidence may include the statements of a credible person (the child, the caretaker, or a witness) that there was an actual offer or purchase of the child's services as a participant in a sex act.

Topic 13: Confirming Presence of Illegal Drugs in a Child's Body

Link to [Policy](#)

For all allegations of illegal drugs in a child's body, gather and document credible evidence that the following factors are present:

Factor 1: The victim is a **child**.

Factor 2: The person responsible for the abuse was a **caretaker** for the child at the time of the abuse.

Factor 3: An **illegal drug** has been found **in the body** of a child. (See definition of "[illegal drug](#).")

Examples of credible evidence include:

- ◆ Statement of a medical practitioner that an illegal drug is present in the child's body, based upon medical testing.
- ◆ Laboratory report for the child that confirms the presence of an illegal drug in the child's body.

Note: When the alleged exposure took place in utero, and a test fails to find illegal drugs in the body of a newborn child, we cannot confirm for presence of illegal drugs, even though the mother may have admitted using illegal drugs during her pregnancy.

We also cannot confirm for denial of critical care on the mother for failure to provide proper supervision on the premise that the child was placed in a situation that endangered the child's health or life, since the danger occurred in utero.

Factor 4: The presence of the illegal drug is a **direct and foreseeable consequence** of the acts or omissions of the child's caretaker. Credible evidence may include:

- ◆ Statement that the caretaker gave the child or caused the child to ingest the illegal drug which was found in the child's body, or knowingly allowed the child access to an illegal drug which the child then ingested.
- ◆ Statement from a medical practitioner that a newborn child has tested positive for the presence of illegal drugs which were ingested by the mother when the child was in utero.

Topic 14: Confirming Manufacture of or Intent to Manufacture a Dangerous Substance

Link to [Policy](#)

For all allegations of manufacture of a dangerous substance or possession of a substance with intent to manufacture, gather and document credible evidence that the following factors are present:

Factor 1: The victim is a **child**.

Factor 2: The person responsible for the abuse was a **caretaker** for the child at the time of the abuse.

Factor 3: The caretaker did any of the following:

- ◆ Unlawfully **manufactured** a dangerous substance, or
- ◆ Knowingly **allowed** the manufacture of a dangerous substance by another person, or
- ◆ **Possessed** a product containing one of the following substances **with the intent** to use the product as a precursor or an intermediary to a dangerous substance:
 - Ephedrine, its salts, optical isomers, or salts of optical isomers, or
 - Pseudoephedrine, its salts, optical isomers, or salts of optical isomers.

Note: The following qualify as a “dangerous substance” for this factor:

- ◆ Amphetamine, its salts, amphetamine isomers, or salts of amphetamine isomers;
- ◆ Methamphetamine, its salts, methamphetamine isomers, or salts of methamphetamine isomers;
- ◆ Any 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 the process of manufacturing an illegal or controlled substance; or
 - As a precursor or intermediary in the manufacturing of an illegal or controlled substance.

Factor 4: The manufacture or possession of the dangerous substance occurred **in the presence of the child.**

Credible evidence may include documentation that:

- ◆ The child was physically present during the manufacture or possession; or
- ◆ The manufacture or possession occurred in the child's home, on the premises, or in a motor vehicle located on the premises; or
- ◆ The manufacture or possession occurred under other circumstances in which a reasonably prudent person would know that the child could see, smell, or hear the manufacture or possession.

Topic 15: Confirming Bestiality in the Presence of a Minor

Link to [Policy](#)

For all allegations of bestiality in the presence of a minor, gather and document credible evidence that the following factors are present:

Factor 1: The victim is a **child**.

Factor 2: The person responsible for the abuse was a **caretaker** for the child at the time of the abuse or the abuse occurred due to the acts of omissions of the caretaker.

Factor 3: Any of the following **sex acts** occurred between a person and a living or dead nonhuman vertebrate animal:

- ◆ Any sexual contact by penetration of the penis into the vagina or anus
- ◆ Contact between the mouth and genitalia
- ◆ Contact between the genitalia of one and the genitalia or anus of the other

Credible evidence may include statements of a credible person (the child, the caretaker, or a witness) indicating that the sex act did occur. The information obtained should include a precise description of the type of activity in which the participants engaged.

Note: A person who performs a sex act with an animal is guilty of an aggravated misdemeanor. Refer the report information to law enforcement for investigation.

Factor 4: The person who committed a sex act with an animal:

- ◆ **Resides** in a home with the child and
- ◆ Committed the sex act **in the presence** of the child.

Credible evidence may include statements of a credible person (the child, the caretaker, or a witness) indicating that:

- ◆ The child was present and
- ◆ The person who committed the sex act resides in the home with the child.

Topic 16: Confirming Allows Access by a Registered Sex Offender

Link to [Policy](#)

NOTE: "Allows access by a registered sex offender" is considered child endangerment, as defined in Iowa Code section 726.6, and shall be reported to law enforcement within 24 hours of intake. Gather and document credible evidence that the following factors are present for the allegation of Allows access by a registered sex offender.

Factor 1: The victim is a **child**. For this type of abuse, "child" means a person up to the age of 14 or up to the age of 18 if the person has a physical or mental disability.

- ◆ A person is considered to have a **physical** disability when the person has a medically diagnosed disability that substantially limits one or more major life activities and requires professional treatment, assistance in self-care, or the purchase of special equipment.
- ◆ A person is considered to have a **mental** disability when:
 - The person has been determined by a qualified mental retardation professional to be mentally retarded; or
 - The person has been diagnosed by a qualified mental health professional to have a psychiatric condition that impairs the person's mental, intellectual, or social functioning, and for which the person requires professional services; or
 - The person has been diagnosed by a qualified mental health professional to have a behavioral or emotional disorder characterized by situationally inappropriate behavior which deviates substantially from behavior appropriate to the person's age or significantly interferes with the person's intellectual, social and personal adjustment.

Factor 2: The person responsible for the abuse was a **caretaker** for the child at the time of the abuse.

NOTE: Consider the caretaker status of all adults who are responsible for the care of a child, including the registered sex offender and the parent, guardian, or custodian of the child. See "[person responsible for the care of a child](#)."

Factor 3: The caretaker knowingly allowed custody, control, or unsupervised access by a person who is required to register or is on the Sex Offender Registry.

For the purposes of this abuse type, a “person having control over a child or a minor” means any of the following:

- ◆ A person who has accepted, undertaken, or assumed supervision of a child or minor from the parent or guardian of the child or minor.
- ◆ A person who has undertaken or assumed temporary supervision of a child or minor without explicit consent from the parent or guardian of the child or minor.
- ◆ A person who operates a motor vehicle with a child or minor present in the vehicle.

Factor 4: The caretaker is not married to the person who is required to register or is on the Sex Offender Registry. (This type of abuse does not apply when the caretaker is married to and living with the registered sex offender or a person is required to register.)

Factor 5: The caretaker is not the parent or guardian of the person who is required to register or is on the Sex Offender Registry when the sex offender is under the age of 18.

Factor 6: At the time when the unsupervised access, custody, or control occurred, the caretaker knew or should have known that the person was required to register or was on the Sex Offender Registry.

To confirm this type of abuse, a preponderance of evidence is required to determine that the caretaker knew the person was registered on the Sex Offender Registry or knew the person was required to register.

Denial of critical care through failure to provide proper supervision applies if:

- ◆ The persons responsible for the care of the child are not providing proper supervision to protect the child from sexual abuse by the sex offender parent, stepparent, the minor sex offender in the home, or other registered sex offender regardless of whether they reside in the home.
- ◆ The sex offender exposes the offender’s own child or other children in the home to the endangerment of sexual abuse by having unsupervised access to the child or other children.

The denial of critical care finding will require exploration of the danger the registered sex offender poses to the child. Include:

- ◆ Information regarding the purpose of a public Sex Offender Registry, and
- ◆ Documentation of contact with the probation or parole officer,
- ◆ Documentation of:
 - The probation or parole terms regarding contact with children under age 18 and
 - What ongoing involvement with treatment or support was recommended to avoid reoffending.
- ◆ Document the presence or absence of any no-contact orders.
- ◆ Documentation of whether sex offender treatment was completed or not completed.
- ◆ Documentation of the written treatment recommendations for contact for children under age 18.
- ◆ Documentation of any reoffense or charges after treatment.

Protective disclosure policy allows you to inform the caretaker that a person has a record of founded child abuse or is registered or required to register on the Sex Offender Registry.

Topic 16A: Confirming Allows Access to Obscene Material

Link to [Procedure](#)

Factor 1: The victim is a **child**.

Factor 2: The person responsible for the abuse was a **caretaker** for the child at the time of the abuse.

Factor 3: The caretaker has knowingly done one of the following:

- ◆ Permitted the child to view obscene material.
- ◆ Disseminated obscene material to the child.
- ◆ Exhibited obscene material to the child.

Credible evidence may include:

- ◆ Statements of a credible person (the child, the caretaker, or a witness) indicating that the child was allowed to view, observe, possess, or touch the obscene material.

The information obtained should include a precise description of the access the child had to the material, including a description of the incident.

- ◆ Physical evidence of obscene material observed or documented by the worker.

NOTE: Report to law enforcement within 24 hours **all** allegations made under this category, for the act may be a violation of Iowa Code 728.2, "any person, other than the parent or guardian of the minor, who knowingly disseminates or exhibits obscene material to a minor, including the exhibition of obscene material so that it can be observed by a minor on or off the premises where it is displayed, is guilty of a public offense."

Definitions of related concepts include:

- ◆ "**Knowingly allows**" means being aware of the character of the matter; to consciously, with knowledge or scienter*, let or permit.
- ◆ "**Access**" means a way or means of approaching, getting, or using; the opportunity to enter or get into.

NOTE: Accidental or incidental access does not constitute abuse.

- ◆ **“Disseminate”** means to transfer possession, with or without consideration.
- ◆ **“Exhibit”** means to offer or expose to view, to display, to present for inspection, or to place on show.
- ◆ **“Obscene material”** means any material which:
 - Depicts or describe the genitals, sex acts, masturbation, excretory functions or sadomasochistic abuse;
 - The average person, taking the material as a whole and applying contemporary community standards with respect to what is suitable material for minors, would find appeals to the prurient interest and is patently offensive; and
 - Taken as a whole, lacks serious literary, scientific, political or artistic value.
- ◆ **“Material”** means:
 - Any book, magazine, newspaper or other printed or written material; or
 - Any picture, drawing, photograph, motion picture, or other pictorial representation; or
 - Any statue or other figure; or
 - Any recording, transcription or mechanical, chemical or electrical reproduction; or
 - Any other articles, equipment, or machines.

* **Scienter** is a legal term that refers to intent or knowledge of wrongdoing. This means that an offending party has knowledge of the “wrongness” of an act or event prior to committing it.

Topic 17: Injury or Risk is Minor, Isolated, and Unlikely to Reoccur

Link to [CPS Assessment Procedure](#)

Determining if Injury or Risk of Injury Was Minor

To determine whether a **physical injury** was minor, consider:

- ◆ The location and size of the injury.
- ◆ The force used to inflict the injury.
- ◆ The potential of greater injury to the child.
- ◆ The age, medical condition, mental and physical maturity, and functioning level of the child.

“Minor” physical injuries may include injuries such as red marks and faint bruising, taking into account the child’s age and the size and location of the injury. For example, grab marks on the upper arms of an adolescent may be considered minor, but the same type of injury on a toddler would not be minor.

To determine whether a report of child abuse confirmed for denial of critical care by failure to provide proper **supervision** or denial of critical care by failure to provide adequate **clothing** was minor, consider:

- ◆ The length of time the endangerment occurred.
- ◆ The likelihood that the child would have suffered injury or death.
- ◆ The age, medical condition, mental and physical maturity, and functioning level of the child.

If the injury was **not minor**, the confirmed report shall be **founded**, regardless of the isolated or likelihood of reoccurrence criteria.

Determining if Injury or Risk of Injury Was Isolated

To determine whether a report of child abuse confirmed for physical abuse or confirmed for denial of critical care for failure to provide proper supervision or for failure to provide adequate clothing was isolated, document that:

- ◆ There are no other reports of child abuse confirmed, or
- ◆ The information gathered in the current assessment supports the evidence that the incident was an isolated occurrence.

Determining if Injury or Risk of Injury Is Unlikely to Reoccur

To determine whether a report of child abuse confirmed for physical abuse or confirmed for denial of critical care for failure to provide proper supervision or for failure to provide adequate clothing is unlikely to reoccur, consider:

- ◆ The responsible caretaker's response to the incident of abuse and receptiveness to alternative methods of discipline, care, or supervision.
- ◆ Whether any factors contributing to the abuse continue to exist, are ongoing, or are no longer present.

Example of rationale:

The report is confirmed for denial of critical care by failure to provide proper supervision. By all accounts, the child, age 5, was left home alone and unattended from approximately 7:30 a.m. to 9:30 a.m.

The child was left alone because of inadequate child care arrangements. The mother left for work at 7:30 a.m. as usual, believing that the babysitter was en route to the home. The babysitter had car trouble and was delayed about two hours.

While the child was clearly not adequately supervised, all parties have assured that it has never happened previously, and that it will not reoccur. The mother will wait for the babysitter to arrive before leaving for work.

The child clearly was placed at risk. However, the child is seen as relatively trustworthy and did have a telephone at his disposal. The child stated that in the event of an emergency, he would either vacate the house or call 911.

The criteria of minor, isolated, and unlikely to reoccur have been met. Therefore, the report is confirmed but is not placed on the Registry as a founded report.

Topic 18: Protective Service Alerts

Link to [CPS Assessment Procedure](#)

The STAR system CABA screen contains information on both in-state and out-of-state protective service “alerts.” STAR maintains protective service alerts for six months.

Contact the Central Abuse Registry and request a protective service alert when you have protective concerns about a family subject to an ongoing assessment who moves and cannot be located.

Do not request a protective service alert unless you believe this is necessary to protect the alleged victim. If you do not believe there is an immediate threat to the child subject, request assistance in completing the assessment from the unit that serves the location where the family has moved, if known.

Also notify juvenile court authorities of the family’s move if:

- ◆ The family has an open juvenile court case, or
- ◆ You believe that the family’s departure presents an immediate threat to the child subject’s life or health.

To request an alert, provide Registry staff with as much information about the family as possible. Include:

- ◆ Names
- ◆ Birth dates
- ◆ Social security numbers
- ◆ Descriptions of family members, as available
- ◆ The assessment of potential danger to children within the family
- ◆ The possible location of the family, if known

Draft an individual memo to the Registry on letterhead, using the suggested format. FAX the memo to the Central Abuse Registry at (515) 242-6884.

Upon receipt of this information, the Central Abuse Registry

- ◆ Transmits your memo to all service area offices in Iowa and any child abuse offices in other states, as appropriate.
- ◆ Enters the information into STAR.

Protective Service Alert Sample Memo

Date:

Subject: Protective Service Alert

Caretakers: Fred N DOB: 4-1-60 SS#: xxx-xx-xxxx

 Carrie N DOB: 11-3-61 SS#: xxx-xx-xxxx

Child: Sheila N DOB: 5-17-97 SS#: xxx-xx-xxxx

Relationship of caretakers to child: mother and father

Nature of Concerns: Sheila N is believed to be at risk as Fred N is a registered sex offender who has not completed sex offender treatment. There is also strong evidence suggestive of domestic violence in the home.

A CINA petition was filed with respect to Sheila and a hearing was scheduled for July 20, 2004. The family did not appear at the hearing and notice was never served on them, as they apparently moved out of the state the first week of July. Carrie N told someone they were moving to California. The court has subsequently issued a removal order for this child.

I am requesting this information be provided to all states' abuse registries for dissemination within the state agencies in attempt to locate this family. Should your records indicate any contact with this family, please call Jane T at the Janesmore County DHS office, at 641-xxx-xxxx.

Topic 19: How to Make a Community Care Referral

Link to [CPS Assessment Procedure](#)

When the Department receives a child abuse report:

- ◆ The 20 working day period for the child protection worker to complete the assessment begins, and
- ◆ The 45-day period for referring eligible cases to community care services begins.

NOTE: Family-centered safety plan services are available during the assessment, regardless of the final determination, if the family meets criteria for eligibility.

If you determine that it is necessary to put services in the home during the course of the assessment, you must complete form [470-3055, Referral and Authorization for Child Welfare Services](#), to authorize family-centered safety plan services. You must get supervisory approval to have services initiated.

At the completion of the assessment, make the appropriate referral to:

- ◆ Department services, or
- ◆ Community care services

If the case does not meet criteria for a referral for Department services or community care services, you may provide information or provide information and referral to close the case.

Consider a community care referral if you check “yes” for all three need consideration questions on the case disposition decision tree. (However, a check in all three boxes doesn’t mean the case automatically must be referred to community care.)

Community care is a voluntary service. All families who agree to community care must sign a release of information to the community care contractor.

Give the family form 470-4128, *Community Care Explanation and Referral*, and obtain a signed release of information. (The release of information form to be used for community care is attached to form 470-4128 in Outlook under Public Folders/State Approved Forms/Service/Community Care.)

You must receive the signed release of information and place it in the case file before making a community care referral. Verbal agreements or faith that a client will return a signed release is not sufficient. The community care contractor cannot legally contact the family unless a release has been signed.

For families that meet criteria for community care services, make entries in STAR to generate the referral date and through the Case Flow system to send the referral. The process is as follows:

1. On the STAT2 screen, select one of the three risk levels by entering an 'X.' This entry must correspond to the final risk level on the *Family Risk Assessment*.
2. Select the "SERVICE ELIGIBILITY CATEGORY" based on the report finding, risk level, and age of the child victims. The SERVICE ELIGIBILITY CATEGORY FIELD has an F2 lookup. STAR has built-in edits that will assist you in selecting the appropriate service category.
3. Following the SERVICE ELIGIBILITY field is an EXCEPTION REASON entry field. This F2 look-up provides you with exception reasons for not making a referral to the service category. Some exception reasons may be used only if the child victim is the only child in the home.

The EXCEPTION REASON entry field for community care will remain open for entry, the same as the RELEASE OBTAINED field and the REFERRAL DATE after supervisory approval. If release is obtained and the contractor can receive the referral within 45 days from the date of intake, you may delete the exception reason and enter a 'Y' entered in the RELEASE OBTAINED field.

4. If the SERVICE ELIGIBILITY CATEGORY is "Community Care," you must enter a 'Y' in the RELEASE OBTAINED field **unless** there is an exception reason listed for not making a community care referral.

NOTE: Information provided to the community care contractor is not considered a "referral" unless **all** required information is provided. Under the existing contract, we must strictly adhere to the 45-day time limit. Therefore, unless **all** required information is provided within the 45 days, the case will be deemed ineligible for community care services.

5. Enter the referral date when the *Child Protective Services Assessment Summary* has been approved by a supervisor, thus completing the assessment. (You can "fast path" directly to the STAT2 screen.) Once the report has been approved, you will receive an alert to make the community care referral.

- ◆ If the referral date is not entered within 36 calendar days from the date of intake, STAR will issue a second alert to you and will also issue an alert to your supervisor that a community care referral needs to be made.
 - ◆ If the referral is not is not entered within 45 calendar days from the date of intake, no referral can be made.
6. When you have entered the referral date on the STAT2 screen, you should go immediately into the Case Flow system.
- ◆ Type in the INCIDENT NUMBER.
 - ◆ To the far right of the Case Flow screen is a section titled "SEND COMMUNITY CARE REFERRAL." Click on the option "ASSESS SUMMARY & FAM RISK" and then click GO. This will pull up your completed report.
 - ◆ At the top right of the screen, click on the button that says "EMAIL REFERRAL TO COMMUNITY CARE." This sends the referral. Please note that the REFERRAL DATE entry and the date that you send the email referral to the community care contractor **must** be the same date.

NOTE: If there is no referral date listed on the STAT2 screen, you will not be able to email your referral. An error message will appear stating there is no referral date on STAR.

Once a community care referral is made, the assessment worker's involvement ends. The two-way release is for the purpose of data sharing only.

Effect of Assessment Addendum on Community Care Eligibility

If an addendum is completed due to new or additional information within six months of the intake date, a community care referral can be made **if**:

- ◆ The addendum information changes the risk level and service eligibility of the original report, and
- ◆ The family was not eligible for community care following the original report.

If the family was eligible for and referred to community care and the new information nullifies that eligibility, an exception may be entered and community care can continue.

New Abuse Report on a Family Receiving Community Care

If a new child abuse referral is assigned on a family that is currently receiving community care services, and the assessment determines that the family is again eligible for a community care referral:

- ◆ On the STAT2 screen, use exception reason "F" (family does not need additional supports), and
- ◆ On the INCIDENT SUMMARY line, type in "Community care currently involved."

If the outcome of the current assessment is that the family is eligible for Department services, you must contact the community care contractor. Email the contractor stating that the Department will now serve the family. Community care services will end and the community care provider will assist with the transition of the case.

Topic 20: Withholding Medical Care Due to Religious Beliefs

Link to [CPS Assessment Procedure](#)

During the assessment of a report that a parent or guardian is not providing necessary medical treatment for a child because of religious beliefs, examine the parent or guardian's religious beliefs that prohibit the provision of medical care. Consider these factors:

- ◆ Whether the parent or guardian belongs to a religion that prohibits all medical care or certain aspects of medical care.
- ◆ Whether the parent or guardian is active in that religion.
- ◆ Whether the religion makes exceptions for serious illness or injuries.

Topic 21: Withholding Treatment to Medically Fragile Children

Link to [CPS Assessment Procedure](#)

When you have received a report alleging the withholding of medically indicated treatment, notify the hospital or health care facility of the receipt of the report and that you will be conduct an assessment with the assistance of a neonatologist.

A child is born with Down's syndrome, a condition that usually results in mental retardation. The parents refuse to authorize hospital personnel to provide the child with any nutrition (infant formula). Although providing formula would not "correct" the probability of a diagnosis of mental retardation, failure to provide formula will ultimately result in the child's death. This report meets the criteria for assessment.

During the assessment, identify the following, where applicable:

- ◆ The name and address of the health care provider.
- ◆ The condition of the child.
- ◆ What decision the child's caretaker made regarding the child's care and treatment.
- ◆ The involvement and recommendation of the health care facility or provider.
- ◆ The extent to which the parents or guardians have consented to treatment.
- ◆ The source of the reporter's information.
- ◆ The identity of others with pertinent information.
- ◆ The diagnosis of the physical, mental, and medical condition of the child.
- ◆ The child's prognosis.
- ◆ The medical or surgical treatment and nutritional sustenance required by the child to sustain life, health, and safety.
- ◆ The special medical, surgical, and nutritional orders given by the child's physician.
- ◆ The date and time of day that the required medical or surgical treatment or nutritional sustenance was withheld or will be withheld.
- ◆ The anticipated result that the lack of treatment will have on the child's life, health, and safety.

Share all the information gathered with the assigned neonatologist for assistance in evaluating the report and determining future course of action.

Topic 22: Safety Elements

Link to [CPS Procedure](#)

Link to [CINA Procedure](#)

Assess child safety throughout the life of the case using three elements:

- ◆ [Threats of maltreatment](#)
- ◆ [Child vulnerability](#)
- ◆ [Caretaker's protective capacities](#)

It is the interplay of safety, risk, and protective capacity (both internal and external elements) that constitutes the elements of the assessment process.

Threats of Maltreatment

Gather information provided by reporting parties and collateral contacts (when appropriate) about that person's knowledge of current maltreatment of a child. Also gather information about any previous incidents of child maltreatment involving the child or family.

Questions to ask and information to consider include:

- ◆ **Current and prior maltreatment:** What is the history of abuse and neglect in this family?
- ◆ **Severity of maltreatment:** Was the current or past abuse severe enough to cause injury to the child?

The severity of maltreatment must be considered in conjunction with the vulnerability of the child. (See below.)

- ◆ **Type of maltreatment:** What type of maltreatment is alleged by the referral? Has there been the same allegation previously?
 - Neglect
 - Physical abuse
 - Sexual abuse
 - Emotional maltreatment
 - Multiple abuse
 - Sexual exploitation
 - Substantial risk
 - Child at risk, sibling abused
 - Caregiver absence or incapacity

- ◆ **Frequency of maltreatment:** Is the maltreatment chronic (steady over a long period) or acute?

Documented history yields information as to whether abuse is chronic, acute, or being initiated. Presence of physical injuries and being underweight (not due to a medical condition) may indicate a history of abuse and neglect. Chronic neglect may have longer lasting consequences than some acute abuse.

Potential sources of information include:

- ◆ Search of previous and current records
- ◆ Mental health and hospital records
- ◆ Interviews with the referent or other people who have experience with the family
- ◆ Interviews with service providers
- ◆ Interview with the family to determine whether services were helpful and reasons that the family did or did not utilize them
- ◆ Interviews with relatives who might be able to assist the family in utilizing services or assuring safety
- ◆ Assessment and interviews with health professionals who have experience in assessing physical injury or neglect
- ◆ Observation of the child to determine if the child was bruised or injured
- ◆ Physical viewing of the child
- ◆ Police records
- ◆ Review of school and day care records

Adapted from *Critical Thinking in Child Welfare Assessment* training curriculum from Berkeley.

Child Strengths and Vulnerability

"Child's strengths" refers to the child's behaviors and attitude that support the child's own safety, permanency, and well-being, including health, education, and social development.

"Child's vulnerability" refers to the child's susceptibility to suffer abuse or neglect based on the child's health, size, mobility, and social and emotional state and the ability of the caregiver to provide protection.

Key characteristics indicating increased child vulnerability include

- ◆ Children with developmental disability
- ◆ Children with mental illness, including withdrawn, fearful or anxious behavior
- ◆ Children with lack of self protection skills
- ◆ Children with substance abusing parents
- ◆ Homeless children
- ◆ Children experiencing chronic neglect

Questions to ask and information to consider include:

- ◆ **Age:** Does the age of the child make them more vulnerable? The younger the child, the more vulnerable—Children are at highest risk from birth to age five.
- ◆ **Health, mental health, and development:**
 - Is the child healthy?
 - Does the child demonstrate resiliency?
 - Does the child have health problems or mental health problems? How serious are they?
 - Does the child show signs of developmental delay? How serious is the delay? Who diagnosed the delay?
 - What is the child's ability to communicate?
- ◆ **Behaviors:**
 - Does the child exhibit behaviors that are typical for the child's age? Are the child's behaviors unusual for the community or culture that the child comes from?

Certain developmental behaviors that are normal increase the child's vulnerability if the parent is unable or unwilling to provide an appropriate response. Examples:

A 2-year-old says no to the mother,

A child wets the bed at age 4 and the doctor states nothing is wrong,

A 14-year-old defies parental rule on curfew.
 - Does the child exhibit behaviors that are challenging, such as bullying, biting other children, etc.
 - Does the child demonstrate an ability to protect oneself and get needs met? Does the child go to others for help?

- Does the child take risks that put them in danger (such as running away, engaging in unprotected sex, etc.)? What is the caregivers' response?
- Does the child abuse drugs or alcohol?
- ◆ **Strengths:** What are the child's strengths (cognitive, motor, social emotional skills)? Are there specific talents the child is interested in or exhibits?

Potential sources of information include:

- ◆ Search of previous and current records
- ◆ Hospital records
- ◆ Interview with the referent, parents, teachers, doctors, family members
- ◆ Interview the child
- ◆ Consultation with public health nurse or developmental psychologist
- ◆ Police records, probation

Adapted from *Critical Thinking in Child Welfare Assessment* training curriculum from Berkeley.

Caretaker's Protective Capacity

Action for Child Protection (2004) clarifies that protective capacity is "a specific quality that can be observed and understood to be part of the way a parent thinks, feels and acts that makes him or her protective."

Assessing parental or caregiver capacities allows you to systematically consider the strengths of the parents or caregivers, and how they might mitigate safety and risk factors. Below are three categories of characteristics, with some questions to consider when assessing them.

Behavior Characteristics

Action for Child Protection defines behavior characteristics as "specific action, activity and performance that is consistent with and results in parenting and protective vigilance." Questions to consider include:

- ◆ Does the caregiver have the physical capacity and energy to care for the child? If the caregiver has a disability (e.g., blindness, deafness, paraplegia, chronic illness), how has the caregiver addressed the disability in parenting the child?
- ◆ Has the caregiver acknowledged and acted on getting the needed supports to effectively parent and protect the child?

- ◆ Does the caregiver demonstrate activities that indicate putting aside one's own needs in favor of the child's needs?
- ◆ Does the caregiver demonstrate adaptability in a changing environment or during a crisis?
- ◆ Does the caregiver demonstrate appropriate assertiveness and responsiveness to the child?
- ◆ Does the caregiver demonstrate actions to protect the child?
- ◆ Does the caregiver demonstrate impulse control?
- ◆ Does the caregiver have a history of protecting the child given any threats to safety of the child?

Cognitive Characteristics

Action for Child Protection defines cognitive characteristics as "the specific intellect, knowledge, understanding and perception that contributes to protective vigilance." Questions to consider include:

- ◆ Is the caregiver oriented to time, place, and space? (Reality orientation)
- ◆ Does the caregiver have an accurate perception of the child? Does the caregiver view the child in an "integrated" manner (i.e., seeing strengths and weaknesses) or see the child as "all good" or "all bad."
- ◆ Does the caregiver have the ability to recognize the child's developmental needs or whether the child has "special needs"?
- ◆ Does the caregiver accurately process the external world stimuli, or is perception distorted (e.g., a battered woman who believes she deserves to be beaten because of something she has done).
- ◆ Does the caregiver understand the role of caregiver is to provide protection to the child?
- ◆ Does the caregiver have the intellectual ability to understand what is needed to raise and protect a child?
- ◆ Does the caregiver accurately assess potential threats to the child?

Emotional Characteristics

Emotional characteristics are defined as, "specific feelings, attitudes and identification with the child and motivation that result in parenting and protective vigilance" (*Action for Child Protection*, 2004).

Questions to consider include:

- ◆ Does the caregiver have an emotional bond to the child? Is there a reciprocal connectedness between the caregiver and the child? Is there a positive connection to the child?
- ◆ Does the caregiver love the child? Does the caregiver have empathy for the child when the child is hurt or afraid?
- ◆ Does the caregiver have the ability to be flexible under stress? Can the caregiver manage adversity?
- ◆ Does the caregiver have the ability to control emotions? If emotionally overwhelmed, does the caregiver reach out to others or expect the child to meet the caregiver's emotional needs?
- ◆ Does the caregiver consistently meet the caregiver's own emotional needs via other adults, services?

Actions Speak Louder Than Words

When assessing the protective capacity of the caregiver, *actions speak louder than words*. A statement by the caregiver that the caregiver has the capacity or will to protect should be respected, but observations of this capacity are very important, as they may have serious consequences for the child.

When interviewing the caregiver, it is important to include questions and observations that support an assessment of behavioral, cognitive, and emotional functioning. Suggested questions and observations include:

- ◆ A history of behavioral responses to crises is a good indicator of what may likely happen. Does the caregiver "lose control?" Does the caregiver take action to solve the crisis? Does the caregiver believe crises are to be avoided at all costs, and cannot problem solve when in the middle of a crisis, even with supports?
- ◆ Watch for caregiver's reactions during a crisis. This often spontaneous behavior will provide insight into how a caregiver feels, thinks, and acts when threatened. Does the caregiver become immobile to the point of inaction (failure to protect)? Does the caregiver move to protect the caregiver rather than the child? Does the caregiver actively blame the child for the crisis?

- ◆ Recognition of caregiver anger or “righteous indignation” at first is appropriate and natural. How a caregiver acts beyond the anger is the important key. Once the initial shock and emotional reaction subsides, does the caregiver blame everyone else for the “interference?” Can the caregiver recognize the protective and safety issues?
- ◆ What are the dynamics of the relationship of multiple caregivers? Does the relationship involve domestic violence? What is the nature and length of the domestic violence? What efforts have been made by the victim to protect the child? Does the victim align with the batterer?
- ◆ Does the caregiver actively engage in a plan to protect the child from further harm? Is the plan workable? Does the plan have action steps that the caregiver has made?
- ◆ Does the caregiver demonstrate actions that are consistent with verbal intent or is it contradictory?

Detailed interviewing and information gatherings from other sources is critical for an accurate assessment. Suggestions for additional activities include:

- ◆ What do others say about the caregiver’s parenting and ability to protect and the history of protecting the child?
- ◆ What is the documented history that indicates the caregiver’s actions in protecting the child?

Assessing Environmental Protective Capacities

While the assessment of the caregiver’s protective capacities is critical, an assessment of environmental capacities may also mitigate the safety concerns and risk of harm to a child. Categories of environmental protective capacities, with questions and considerations that may be considered when assessing them, include:

- ◆ **Formal family and kinship relationships that contribute to the protection of the child:** What are the formal kinships within a family? (grandparents, aunts, uncles, siblings, stepparents and their families, half-siblings, gay partners raising children, etc.)
- ◆ **Informal family and kinship relationships:** What are the informal relationships? (family friends, godparents, tribal connections, “pseudo” relatives, mentors, divorced stepparent who maintains parental relationship with the child, etc.)

- ◆ **Formal agency supports:** What are the agencies that have been or currently involved with the family (drug treatment, children's hospital, nonprofit agencies, food banks, schools, employment training, parenting classes, domestic violence programs, etc.)?

Previous agency involvement may have been seen as beneficial and can be called upon again.

- ◆ **Informal community supports:** What are the community supports that may or may not be readily apparent (local parent support groups, informal mentors, neighbors, neighborhood organizations, babysitting clubs, library reading times, etc.)?

- ◆ **Financial supports:**

- Employment, unemployment, disability, retirement benefits
- Family Investment Program, general relief, SSI
- Scholarships, grants

- ◆ **Spiritual, congregational, or ministerial supports:**

- Churches, ministries, prayer groups, synagogues, temples, mosques
- Spiritual leaders within a faith

- ◆ **Native Americans tribe:** Is the family a member of a tribe locally, or elsewhere? Are there ICWA agencies that can provide services? (elders within a tribe, tribal chairpersons, liaisons to the tribes, Indian health agencies)

- ◆ Concrete needs being met such as food, clothing, shelter (low income housing, food banks, clothing stores, emergency shelters, subsidized housing)

Adapted from *Critical Thinking in Child Welfare Assessment* training curriculum from Berkeley.

Topic 23: Safety Plan Services

Link to [CPS Procedure](#)

Link to [CINA Procedure](#)

Safety plan services (service code A53X) is an intensive time-limited service package targeted to children and families who:

- ◆ Come to the Department's attention through either a child protective or CINA assessment and
- ◆ Are determined by the Department worker to be conditionally safe and in need of services to monitor and promote safety during the assessment period.

Safety plan services are purchased services targeted to children and families during a child protective assessment or a CINA assessment that are intended to:

- ◆ Keep children safe from neglect and abuse;
- ◆ Maintain or improve a child's safety status through provision of timely and culturally sensitive safety enhancement interventions;
- ◆ Provide the family with needed resources; and
- ◆ Encourage and support the family to begin making positive changes immediately.

Safety plan services provide a flexible array of monitoring activities and interventions to supplement the family's protective capacities needed to keep children safe. Services may be provided in the child's home or in locations as specified in the child's safety plan.

The service is provided on a time-limited basis of a maximum of two 15-calendar-day units of service during the 20-business-day child protective assessment or CINA assessment. The date of the Department referral is considered the first day of services.

Eligibility Criteria

Cases eligible for safety plan services will consist only of children who:

- ◆ Have been determined by the Department worker to be conditionally safe during the course of a child protective or CINA assessment,
- ◆ Have a safety plan developed by the Department worker, and
- ◆ Have been determined by the Department worker to need safety plan services to prevent their removal from their home or current placement.

NOTE: For purposes of safety plan services, a "case" is defined as:

- ◆ The child or children on whom the Department has initiated a child protective or CINA assessment; and
- ◆ Any whole, half, or step siblings of that child or children who reside in the same household; and
- ◆ The parents, stepparents, adoptive parents, or caretakers of the alleged abuse victims.

Not all children receiving assessment may be referred for purchased safety plan services. Examples of situations where safety plan services will not be purchased include, but are not limited to, the following:

- ◆ Upon determination that the child is in a "conditionally safe" status, a safety plan is developed with the family, and the Department determines that the family's own informal supports and existing community resources are sufficient to assure safety during the assessment without the need for purchased services.
- ◆ The safety assessment determines that the child is in an "unsafe" status, and the worker moves forward with plans to remove the child from the home.
- ◆ If a safety assessment determines that the child is in a "safe" status, the case cannot be referred for safety plan services.

Assignment to Contractor

The Department has entered into contracts with contractors within each of the following service areas: Ames, Council Bluffs, Davenport, Dubuque, Sioux City, and Waterloo; and with contractors within each of the two sub-areas in the Cedar Rapids and Des Moines service areas. Contractors were selected through a competitive bidding process.

Within each contract area, a Case Referral Assignment Tracking System will assign new case referrals to the two contractors on a 50/50, every-other-case referral basis. The system will be designed to ensure that each contractor is at equal risk of receiving complex, difficult cases. This system has the following features:

- ◆ The case referral assignment process will be used for both safety plan services and for family safety, risk, and permanency services referrals.
- ◆ If a contractor is assigned a case for safety plan services and that case later needs family safety, risk, and permanency services, the same contractor will maintain the case for those services.
- ◆ The system allows for case-specific assignment overrides to provide service continuity for cases in which a case previously received services from one of the contractors or its subcontractor, and either the family or Department worker believes it would be beneficial for services to be delivered by that contractor or subcontractor.
- ◆ If an override assigns a case outside of the alternating assignment order, the Case Referral Assignment System will recognize this change and equalize future referrals.

Contractor Expectations

Each contractor providing safety plan services is required to meet the following expectations:

- ◆ The contractor must be available to take Department referrals 24 hours a day, seven days a week.
- ◆ The contractor must call the Department worker back within one hour of any new referral received.
- ◆ The contractor must make face-to-face contact with the alleged child victims and parents, or with others identified on the Department safety plan, within 24 hours of the time of the initial Department referral call.

- ◆ The contractor must send the Department worker an e-mail confirming the date and time of the first meeting within 24 hours of the visit.
- ◆ The contractor must provide services according to the Department's individual safety plan.
- ◆ The contractor must use evidence-based practices to the greatest possible extent in order to keep children safe during the service delivery period.
- ◆ The contractor must maintain daily face-to-face contact, or daily face-to-face contact attempts, with the alleged child victims and parents or others identified on the safety plan, unless a different contact frequency is directed by the Department worker and specified on the safety plan.
- ◆ The contractor must immediately inform the Department worker of any safety issues or concerns regarding the children.
- ◆ The contractor must send the Department worker an e-mail contact summary within 24 hours of each contact with the child and family. If the contractor's e-mail service is down, this summary can be faxed to the Department worker.
- ◆ The contractor must attend all family team meetings on the case during the service period and attend any court hearings on request of the court or the Department worker.
- ◆ The contractor must respond within 2 hours, either by telephone or in-person, to any crisis that threatens the safety of the children and must provide a follow up report on the crisis to the Department worker.
- ◆ The contractor must send the Department worker via mail or e-mail a written summary report for each 15-calendar-day service unit within 24 hours of the 15th day. At a minimum, this report must include:
 - The date of the first face-to-face contact on the case.
 - Verification that case contacts and safety checks were conducted as indicated or directed on the Department safety plan.
 - Information on contractor attendance at any family team meetings and court hearings on the case.
 - Contractor responses to any case crises, and documentation that the contractor responded to the situation within two hours.
 - Information on any child removals that occurred during the service period.
 - Information on case safety status at service termination.

Service Activities

Safety plan services will be individualized and will focus on the issues and tasks identified for each case in the Department safety plan. Contractors are required to be flexible and tailor their interventions in response to the directions given to them in the *Safety Plan*. Core activities are expected to include, but are not limited to, the following:

- ◆ **Safety checks and supervision** activities to make in-person visits to monitor and evaluate the safety of children in a family in order to carry out the safety plan. The focus is on regular monitoring and assessment of:
 - The protective capacities of the caregivers,
 - Vulnerabilities of the child, and
 - Threats of maltreatment to the child as defined in the [Safety Plan, form 470-4461](#).
- ◆ Activities to provide assistance and basic education for families regarding **household management** skills and capacities related to immediate safety issues identified in the safety plan.
- ◆ Either direct **transportation** by the contractor or provision of funding for transportation can be provided when transportation would assist in moving the child from “conditionally safe” to “safe” status. An example would be providing assistance for a child to access respite care to reduce family stress.

Safety service transportation should focus **only** on assisting on moving a child and or family to a safe condition and **not** on meeting other service-related transportation needs.
- ◆ Activities or provision of funding to help children and their family secure necessary **essential supports**, such as food, diapers, cleaning supplies, house fumigation, etc., and to connect the children and family to community resources and informal supports as identified in the safety plan.
- ◆ Activities to arrange for **respite** care or protective child care assistance, if identified in the safety plan.
- ◆ Activities to monitor and ensure that a parent is keeping **mental health or substance abuse treatment** appointments and is taking prescribed psychotropic medication, if appropriate to the case situation.
- ◆ Activities to inspect and monitor the safety of the **home environment**.

Payments for Services

The maximum rate for each 15-calendar-day unit of safety plan services shall not exceed the amount specified in the contract. However, if the Iowa Legislature enacts legislation to increase child welfare provider rates, the rates for safety plan services will be adjusted accordingly.

The start date for the safety plan service unit is the date of the Department referral, as noted and written on the *Safety Plan*. The contractor's ability to receive payment in a case will be evaluated and determined as follows:

- ◆ The contractor will receive the amount specified in the contract for the case if the contractor does all of the following:
 - Makes a timely response to the Department worker within one hour following the referral,
 - Makes face-to-face contact with the alleged victims and parents within 24 hours of referral, and
 - Sends an e-mail confirmation to the Department worker within 24 hours of the first contact.
- ◆ The contractor will be able to receive a payment for the case in the amount specified in the contract if the contractor maintains daily face-to-face contact with the alleged child victims and parents or others identified in the safety plan during the service delivery period, unless otherwise specified by the Department worker in the safety plan.
- ◆ The contractor will be able to receive a payment for the case in the amount specified in the contract if the contractor submits e-mail updates to the Department worker within 24 hours of each and every face-to-face contact or attempted contact with the alleged child victims and parents or others as identified in the safety plan during the service period.
- ◆ The contractor will be able to receive a payment of \$50 for the case if the children in the case did not experience any additional abuse or neglect while safety plan services were being provided.
- ◆ The contractor will be able to receive a payment of \$50 for the case if the safety status of the children in the case was maintained or improved by the end of the safety plan services.

Dispute Resolution Procedures

As part of the contracts with providers of safety plan services, the Department has implemented a protocol for resolution of service provision disputes that includes the following procedures:

1. If a Department worker directs a contractor (or subcontractor) to provide a level of interventions or supports beyond what the contractor feel is necessary or reasonable, the contractor may communicate the basis of that belief in writing or via e-mail to the Department worker and supervisor.
2. The contractor is expected and required to provide services at the level directed by the Department worker while the matter is being resolved and assessed by the Department supervisor.
3. The contractor and the Department shall make every effort resolve disputes at the lowest level possible, at the respective worker and supervisor level if possible, and generally within five days of receipt of the request for review.
4. The Department supervisor will notify the contractor of the decision resulting from the review via e-mail or through a written letter.
5. If a contractor is not satisfied with the results of the Department supervisor's review, the contractor may refer the case situation in writing or via e-mail to the DHS service area manager or designee for review.
6. The service area manager or designee will review the situation, the service interventions and supports requested by the Department worker, and the communication from the contractor concerning why this level of intervention is believed to be unnecessary or unreasonable, and make a decision, generally within seven business days of the date of the review request.
7. The decision of the service area manager or designee will be communicated in writing to the contractor. This decision will be the final decision.

In addition to this dispute resolution protocol for case specific situations, there will be contract oversight and advisory committees for each service area or subarea in which contracts are awarded. These committees shall meet at least quarterly to review service operation and resolve any service delivery issues.

Department service area and Central Office staff will meet with contractors during these committee meetings to identify case situations in which disputes have arisen and work to clarify contract performance expectations in order to improve service delivery.

Department supervisors should communicate with both their staff and social work administrator concerning cases in which contractors are using the dispute resolution protocol, so that general issues in these cases can be identified and considered by the contract oversight committee in making necessary program and contract adjustments.

Satisfaction Surveys

Under all contracts for safety plan services, results of family and Department worker satisfaction surveys are one method used to evaluate the contractor's performance.

The Department will develop family satisfaction survey with input from the selected contractors and will also design a Department worker satisfaction survey. The satisfaction survey process will work in the following manner:

- ◆ **Family satisfaction surveys:** Each contractor shall ensure that a copy of this survey is supplied to each family that receives safety plan services.
- ◆ **Department worker satisfaction surveys:** The Department will send the worker satisfaction survey electronically to every Department worker who referred a case to a contractor for safety plan services. When you receive a worker satisfaction survey, respond in a timely manner so that your perspectives on contractor performance can be used to help inform program improvement activities.

Survey results will be reviewed and analyzed by staff of the Department's Division of Results-Based Accountability and a report of the results for each contractor will be sent to the Department contract monitor. Each contractor is expected to achieve a minimum satisfaction level of 85% on both the family and Department worker satisfaction surveys each quarter.

A contractor that falls below this satisfaction percentage during any quarter will be required to prepare a program improvement plan that describes specific steps the contractor will take to improve the satisfaction results during the next six-month period. The contractor must submit the plan to the Department contract owner for approval.