MISPLACED TRUST

An Investigation of the Death of Sabrina Ray

Iowa Office of Ombudsman

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Redacted Public Version

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From the Ombudsman

> [The girls] had seen the Department of Human Services come and go, but they were still trapped in a hell that no one could begin to fathom or comprehend.
>
> *Officer Josh Sienkiewicz, Perry Police Department*

In the spring of 2017, I heard a news report that sent a chill down my spine. "Not again," I thought. A 16-year-old girl named Sabrina Ray had died at the home of her adoptive parents, possibly from starvation. The news suggested that the Iowa Department of Human Services (DHS) had had extensive involvement with Sabrina's family.

It had been less than six months since I had self-initiated an investigation into the starvation death of a different 16-year-old girl, Natalie Finn. Natalie was also adopted, and her family had also been involved with DHS. We would later release an investigative report in that case, "A Tragedy of Errors: An Investigation of the Death of Natalie Finn," on February 17, 2020. The Ray case clearly called out for an investigation, too.

Sadly, there is a third case of a child death that we are continuing to investigate.

This report, which focuses on the Ray family, details problems we found with multiple units of DHS, including its child abuse intake and assessment process, daycare licensing, foster care licensing, and foster care ongoing services. As part of our investigation, we also examined the role of the Mid-Iowa Family Therapy Clinic (Mid-Iowa), which was contracted by DHS to provide Family, Safety, Risk, and Permanency (FSRP) services to children who were placed in foster care with the Rays. The report makes 13 recommendations to address the problems we found and to strengthen Iowa's child-welfare programs.

Sabrina and Natalie's cases were similar in some ways, but very different in others. Both were equally tragic. We identified some common concerns in both investigations, finding that child abuse reports were wrongly rejected, and noting shortcomings with the thoroughness and accuracy of caseworkers' records. We again found that current DHS record-retention policies hinder the ability of agency workers to identify patterns of abuse.

In some ways, though, DHS' failings in the Ray case were even more acute than with the Finns. In the Ray household, the mistreatment of children extended beyond the immediate family, to the parents' in-home daycare and foster care children. Unlike the Finn case, where Natalie's mother obstructed authorities' attempts to inspect the home, DHS workers and contractors were regularly in Sabrina's house and in contact with the family over a period of years. Suspicions of abuse were certainly present among those who interacted with children at the Ray household. Unfortunately and sadly, a lack of communication among those workers weakened the oversight that could have discovered that abuse.

We also found it unfathomable that DHS conducted no internal review of its own actions and decisions leading up to Sabrina's death. We have renewed our plea to the Iowa Legislature to re-

evaluate its expectations for the Child Fatality Review Committee and other existing oversight bodies responsible for reviewing child deaths.

It is no exaggeration to say that this investigation brought me to tears. I cried at the atrocities Sabrina was subjected to, the unspeakable abuse and unimaginable pain she endured. I cried for her siblings and the foster care children who witnessed the abuse, or were subjected to it. And I cried for those who tried to sound the alarm, especially a foster-care worker named Shelby Messersmith, whose concerns were dismissed or silenced by her supervisors.

I was also angry. Angry that so many trained officials at DHS had misplaced their trust in individuals that were so depraved. Angry that, once again, an undersized budget contributed to the lack of rigorous oversight of key DHS functions. Angry that the state paid Sabrina's adoptive parents more than $640,000 between 2006 and 2017 to care for children, while they abused some of those children.

And now, I am fearful. Fearful because many children are staying home from school this fall due to the health threat posed by COVID-19. Sabrina, too, stayed home during her time in the Ray household, purportedly for home schooling. The fact is, the potential for child abuse to occur is much greater when children fall outside the reach of conscientious and inquisitive school officials. This past April, a month after schools were first closed due to COVID-19, statistics showed that child abuse reports to DHS had fallen by half when compared to 2019. I am not advocating for or against home schooling or online learning. That is a very personal decision each family needs to make. But I am fearful that those who try to hide abuse will now have an easier and greater opportunity to do so. I cannot stress enough that we must all remain vigilant about identifying and reporting suspected child abuse, especially during these challenging and unsettling times. I urge you to trust your instincts.

I again pledge to the citizens of Iowa that the Ombudsman's Office will stand fast in its efforts to identify problems and make recommendations to policymakers to protect our children and grandchildren. I look forward to continue working with DHS Director Kelly Garcia and her staff to ensure the safety of all of Iowa's children. Garcia was not serving as director at the time Sabrina and Natalie lost their lives, but she has accepted responsibility nonetheless and has acknowledged the need for improvement by adopting most of my recommendations. I will also ask the Legislature to join in these continuing discussions. We must all do better for our children.

Lastly, I want to thank my entire staff, especially the investigators and editors. Our reports are a group effort that require thousands of hours of research, interviews, analysis, and debate. Your hard work, dedication, and sacrifices make a difference in the lives of the citizens we serve.

Kristie Hirschman
Ombudsman

Executive Summary

Just before 6:30 p.m. on May 12, 2017, two Perry police officers were dispatched to 1708 1st Street in Perry in response to a report that a minor female was not breathing. Upon arrival to the Ray home, Officer Josh Sienkiewicz described what he saw as "the most horrific scene in my entire career and life." Sixteen-year-old Sabrina Ray was found lying on a small mattress on the floor wearing a diaper and tank-top. Officer Sienkiewicz observed that Sabrina's body was "nearly withered out of existence." Sabrina was already deceased, and resuscitation efforts were considered futile by emergency personnel. EMS paramedics noted that Sabrina had skeletal features and appeared to be extremely malnourished.

Officer Sienkiewicz observed that Sabrina's bedroom window was covered, and there was a baby monitor-like camera in the room. A magnetic type alarm had been installed on the bedroom door. He also observed that a lock of some type had been on the door and then removed. Scene photographs reveal that screws were placed to keep the windows from opening and there were holes on the bedroom door for a padlock. There were also locks and alarms on food and beverage pantries in the kitchen and family room.

On the day she died, Sabrina's adoptive parents, Marc and Misty Ray, were en route to Disney World with her adoptive brothers. Present in the home at the time of Sabrina's death were her adoptive sisters; her adoptive grandmother, Carla Bousman; and her adoptive cousin, Josie Bousman.

Sabrina's cause of death was later determined by medical examiners to be severe malnutrition due to denial of critical care. The 16-year-old was 4 feet, 7½ inches tall and weighed just 56 pounds. The autopsy revealed that, based on the size and condition of her internal organs, Sabrina was likely subject to starvation over a long period of time.

What was discovered during the criminal investigation resulted in charges and convictions against five family members. Sabrina's mother, Misty, was sentenced to life plus 20 years in prison. Sabrina's father, Marc, received an 80-year sentence.

Carla Bousman, her grandmother, received a 20-year sentence. Josie Bousman, her cousin, was sentenced to 14 years, and Sabrina's brother, Justin Ray, received a 10-year sentence.

Numerous child abuse reports were received by the Iowa Department of Human Services (DHS) following Sabrina's death, and the investigations concluded with founded child abuse allegations against Misty, Marc, Justin, Carla, and Josie. These child abuse reports concerned not only the Ray children, but also children who were in Marc and Misty's in-home daycare as well.

DHS was already intimately familiar with the Ray family before Sabrina's death. The agency was involved with them through licensing the home as a child-development home (in-home daycare). The Rays also were previously an approved and licensed foster care home, and had been the subject of a total of 11 child abuse reports involving foster care children, Sabrina and her siblings.

OMBUDSMAN INVESTIGATION AND THE ROLE OF OTHER OVERSIGHT BODIES

We first heard of Sabrina Ray through media reports a few days after her death on May 16, 2017. This was the third child death brought to our attention within seven months in which DHS was involved with the family. Our investigative report on one of those cases, "A Tragedy of Errors: An Investigation of the Death of Natalie Finn," was released on February 17, 2020. That report made 14 recommendations to DHS to improve policies and procedures. The third child-death case remains under investigation by our office.

As noted in our investigation of the death of Natalie Finn, there are other government bodies – particularly the Child Fatality Review Committee – that could have reviewed DHS's actions in these cases. After the death of Shelby Duis in 2000, Iowa lawmakers approved a new law authorizing the creation of an ad hoc committee to investigate DHS-related child fatalities. The law authorizes the State Medical Examiner to establish a Child Fatality Review Committee (CFRC) to "immediately review the child abuse assessments which involve the fatality of a child under age eighteen … to determine whether the department of human services and others involved with the case of child abuse responded appropriately." Since the legislation was passed in 2000, *the committee has never been convened*.

Other potential oversight entities all have had significant limitations in their resources and authority. By default, the Ombudsman was the only entity capable of conducting an independent systemic review of DHS's actions. We questioned in the Finn report what the Legislature's expectations are of all these entities – particularly the CFRC – to review child fatalities.

Legislative notification

Pursuant to Iowa Code section 2C.16(3), the Ombudsman is giving notice to the Legislature of the need to re-evaluate its expectations of the Child Fatality Review Committee and other existing child-fatality oversight bodies. Optimally, any reviewing entity would be independent of DHS, have broad access to records and resources, and be adequately funded and staffed to complete comprehensive and detailed reviews of DHS's involvement in child fatality cases. Reviews should be mandatory and the entity would have authority to investigate all aspects of DHS's involvement in a case, including rejected child abuse intakes.

MARC AND MISTY RAYS' DAYCARE AND FOSTER CARE LICENSES

Rays' daycare license

At the time of Sabrina's death, Marc and Misty were operating a licensed daycare out of their home named "Rays of Sunshine."

Throughout the 13 years that the Rays operated a licensed child-development home, DHS conducted inspections of the daycare, as well as reviews of the Rays' re-registration every two

years. On a number of occasions, DHS determined that the daycare was out of compliance in certain areas, though no action was taken against the Rays' license.

DHS's unannounced home compliance visit on December 1, 2016, was its last at the Ray home prior to Sabrina's death five months later.

Rays' foster care license

In addition to obtaining a daycare license, the Rays also received a foster care license through DHS.

According to DHS records, the Rays had a total of 23 foster care placements between 2006 and 2014, which resulted in four adoptions, including Sabrina's. The last children placed in foster care with the Rays left the home on July 28, 2014.

During the nearly 10 years the Rays were foster parents, their license was never suspended or revoked. The license was once placed on "hold" on April 10, 2014, following receipt of a child abuse report that same day that involved physical abuse and "denial of critical care" allegations. The hold did not formally suspend or terminate the Rays' license, but it meant that they would not receive any future foster care placements.

Despite the hold, DHS kept three foster care placements in the home.

FIVE CHILD ABUSE REPORTS RECEIVED BETWEEN 2010-2013

2010 child abuse intakes and assessments

DHS received a child abuse report from a school employee on October 15, 2010, concerning a 5-year-old foster care child living with the Rays. The reporter alleged that Marc and Misty had locked the child in a closet as a form of punishment when she defecated in her pants.

The field worker assigned to the child abuse assessment interviewed the victim and made multiple unannounced visits to the home and inspected the closets in the home. One bedroom was found to have a lock on the outside of the door, but it was not functioning. Another bedroom, the one belonging to the alleged child victim and other girls, had an alarm on the door, which Marc explained was to let them know when the children were up at night, and was not a lock. Marc denied locking the child in a closet.

The assessment summary concluded that it could not be determined whether the Rays were using the kind of discipline that had been alleged.

In our review of this intake report, we discovered that another child abuse report involving the Ray family had been made just two months prior, on August 20, 2010. DHS had expunged the intake and assessment pursuant to its record retention schedule, so we were not able to determine who the reporter was, what type of abuse was alleged, or the outcome. DHS records appeared to suggest that this intake was accepted, and an assessment was completed on September 21, 2010. Marc and Misty were the alleged perpetrators and one of Sabrina's sister was identified as the alleged victim. At that time, the alleged child victim would have been 5 years old.

On November 2, 2010, the DHS field worker who handled the October assessment made her own report to DHS with concerns about the Rays' ability to meet the foster care child's mental-health needs, as the child had not been receiving counseling. The intake was accepted for a child abuse assessment, and it was determined that services were needed. However, Marc and Misty reported to the field worker that they could no longer handle the foster care child's behaviors, and it was decided that she would be placed in a different living arrangement. The finding of the child abuse assessment was not confirmed.

The 2010 child abuse reports were made at a time when Marc and Misty lived in Carroll, Iowa (in DHS's Western Service Area). Shortly after these reports were made, the family moved to Perry, Iowa (in DHS's Des Moines Service Area). The Western Service Area had concerns about the family and determined that a corrective action plan was needed to address issues. Because the Rays moved back to Perry in January 2011, the responsibility of implementing a corrective action plan was transferred to the Des Moines Service Area.

It does not appear, however, that a corrective plan was ever implemented.

September 13, 2013, rejected intake

DHS received a child abuse report from Shelby Messersmith on September 13, 2013, concerning a 16-year-old foster care child residing with the Rays. Messersmith was a Family Safety, Risk and Permanency (FSRP) services worker who was handling the child's services through a DHS contract during his placement with the Rays. Messersmith alleged that Misty was not refilling the child's Ritalin prescription. She also reported that the Rays had called the foster child a "fat ass" and showed him pictures of his parents on the internet referred to as "meth Facebook pages." The intake was ultimately rejected, but was referred to the DHS ongoing-services worker to be addressed at a family team meeting.

In addition to the report made by Messersmith, DHS's ongoing-services worker for the foster care child contacted a foster care licensing worker because Misty had called the child and other children in the home inappropriate names.

September 20, 2013, accepted intake and assessment (not confirmed)

DHS received another child abuse report from Messersmith on September 20, 2013 – this time concerning three adoptive children in the Ray home. She alleged that Marc and Misty physically abused Sabrina and her sisters and withheld food from the girls as a form of discipline.

The intake was accepted and the Rays admitted to the field worker that they used physical punishment, describing the degree of the contact as an open-handed swat on the bottom or a swat near their mouth. Misty reported that the majority of the time ("85%"), they used time outs as punishment. Marc and Misty denied spanking their children in the basement or taking away the children's food as punishment. The three girls denied that Marc and Misty physically abused them, and reported that they had plenty of food to eat in the home and did not get food taken away as punishment.

The field worker found that the "children were observed to be thin but not abnormally thin," and

the assessment was not confirmed.

September 22, 2013, daycare licensing complaint

A complaint was made to DHS daycare licensing on September 22, 2013, by a mother of a daycare child who was also an employee of Mid-Iowa Family Therapy Clinic, which provided FSRP services on behalf of DHS and where Messersmith worked. The employee reported that Marc and Misty were providing improper meals, improper discipline, and improper supervision. Additionally, she alleged that the Rays called the children degrading nicknames. The employee also stated that Sabrina had become "extremely thin and withdrawn" and was "starved for social interaction."

An investigation was initiated by daycare licensing staff. Two workers visited the Ray home on October 2, 2013, and neither worker observed "any evidence from [the] complaint allegations."

ANALYSIS AND CONCLUSIONS OF 2010-2013 EVENTS

The DHS Employees' Manual indicates that: "When it is alleged that child abuse has occurred in a child-development home, the protective service worker will immediately inform the child care registration worker." The daycare licensing worker's role in an assessment of alleged abuse is to "focus on compliance issues with the child care law and the requirements for registration." When a daycare licensing worker is notified of child abuse allegations, it is considered a complaint against the daycare.

We found no indication that daycare licensing staff were informed about the allegations raised in any of the child abuse reports received about the Rays in 2010 and 2013.

Further, our investigation, as well as our investigation into the death of Natalie Finn, has brought to light the problem of DHS's limited record-retention policy. The absence of any records prevented us from reaching any firm conclusion on the appropriateness of DHS's responses to the August 2010 report on the Rays. This early report could have been an important tool for any intake or assessment worker to connect the dots when additional child abuse reports were made years later. Additionally, the inconsistent retention of child abuse reports and assessments is significant.

Record-retention policies in several other states acknowledge that multiple reports involving the same subjects – regardless of whether an intake was rejected – justify longer retention of child abuse records. We believe that increasing record-retention timeframes by adopting laws similar to those in other states would help DHS staff identify patterns of child abuse.

Identical to the recommendations in our investigation into the death of Natalie Finn, the Ombudsman recommends that DHS:

1. **Modify its administrative rules to increase the retention period for child abuse intakes and assessments as follows:**

a. **At least five years for rejected child abuse intakes, and an additional five years if DHS receives another report concerning the same subjects or any siblings or other children in the same household or in the care of the same adults during that timeframe.**

b. **At least 10 years for "confirmed" and "not confirmed" child abuse assessments, or 10 years from the date of closure of the case file, whichever occurs later. In addition, if DHS receives another report concerning the same subjects or any siblings or other children in the same household or in the care of the same adults during that timeframe, DHS shall retain these abuse assessments for an additional 10 years.**

c. **Indefinitely for "founded" child abuse assessments.**

2014 EVENTS AND ISSUES

Between April and November 2014, DHS received five child abuse reports about the Rays; three were rejected and two were accepted for assessment. During this seven-month time period, other events and issues occurred with the family that were significant to our investigation.

April 10, 2014, accepted intake and assessment (not confirmed)

The first child abuse report was received on April 10, 2014. Three different functions within DHS were involved with the Ray family after this report was made: child abuse intake and assessment, daycare licensing, and foster care licensing.

A mother of a child who was formerly placed in the Rays' foster home alleged that Sabrina (then age 13) and her sisters (then age 9 and 7) did not get fed for weeks at a time and had to fight each other for food. She also alleged that Marc and Misty physically abused Sabrina in the basement, and that there was video footage of one of these incidents. This child abuse report was the second report received by DHS in a six-month period that included nearly identical allegations of physical abuse and failure to provide food to Sabrina and her sisters.

A DHS field worker made an unannounced visit to the Ray home the same day the report was received and interviewed the girls alone. Sabrina and her sisters denied that Marc, Misty, or anyone else had ever hit them or made them fight for food. They also denied that they had to steal food or were made to stand for long periods of time as punishment. The Rays indicated that they typically used time outs for punishment, but there had been a few occasions in which the children were "swatted on their bottoms" with an open hand.

The field worker contacted DHS ongoing-services worker Marcia Hoffman, who was working with the family concerning three foster care children who were placed with the Rays. Hoffman reported that she had made unannounced visits to the home and had never seen any food being withheld or maltreatment of the children. The physical abuse and failure to provide adequate food allegations were determined to be not confirmed.

April 10, 2014, daycare complaint

A referral was made to DHS's daycare licensing unit based on the abuse allegations, and a daycare licensing worker made an unannounced compliance and spot check on the Ray home on April 16, 2014. In addition to interviewing Marc and Misty, the worker reviewed meal plans, discipline policy and practices, the food supply on hand, and the posted menu for the monthly lunches. The worker also observed the daycare children and did not note any concerns. Ultimately, the worker determined that there was no evidence consistent with the reported complaint.

Foster care license placed on "hold" and April 11, 2014, staffing

A DHS foster care licensing worker also received notification of the April 10, 2014, accepted intake and made the decision to place the Rays' foster care license on "hold."

At the time of the April 10 accepted intake, there were three siblings in foster care with the Rays. The children – "the Millers"[1] – were placed with the Rays on April 4, 2014, just six days prior to the child abuse report. The following day, a staffing was held among the foster care licensing, ongoing-services, and the field units of DHS. According to DHS's Confidential Briefing:

> Licensing questioned if foster children should be moved. Ongoing worker Marcia Hoffman, CPW supervisor Jennifer Carlson and ongoing supervisor Mark Chappelle thought they should remain. Plan developed during licensing staffing that they cannot use physical discipline with foster children or day care children.

The April 11 staffing confirmed that the Rays' foster care license would be placed on "hold" for future placements, but the Miller children would not be removed from the placement. A DHS supervisor later told us: "There's something happening there, we don't know what it is – we can't prove it … don't have enough for a suspension or revocation – but we're not going to place any more kids there."

April 24, 2014, rejected intake

While the prior child abuse assessment was still active, FSRP services worker Shelby Messersmith made her third child abuse report to DHS on April 24, 2014, this time involving one of the Miller children.

Messersmith alleged that the child reported that Marc and Misty were forcing him to eat food he did not like, which made him throw up in his mouth. He stated that the Rays would not allow him to go to the restroom when he threw up, and instead made him either swallow it or throw up on his plate and eat it. Messersmith also reported that the child shared that when his 4-year old brother had accidents in his pants, Marc and Misty made him stand in the corner all day.

While making the report of child abuse, Messersmith also stated that Marc and Misty no longer allowed her to come into the home when she dropped the children off after visits, which caused

[1] For confidentiality purposes, we have created a pseudonym for this family.

her more concern about the safety of the children. Messersmith indicated during the child abuse call that she had shared these concerns with the DHS ongoing worker, Hoffman, as well.

The April 24, 2014, child abuse report was rejected. According to the intake document, the case was referred to Hoffman, as well as the foster care licensing worker. We found no indication the intake report was forwarded on to the field worker who still had an open assessment from the April 10 report.

May 7, 2014, rejected intake

DHS received a child abuse report on May 7, 2014, from an adoptive parent of a former foster child at the Rays. This was the third child abuse report made concerning Marc and Misty's care of this child while she was in foster care placement with them.

The child had shared with the reporter that she was subjected to certain punishments while at the Rays, such as drinking soapy water and water with spices in it, and standing all day either against a wall or over a cold vent. The child said that Marc and Misty would make her go without meals and made her bite her sister while the Rays would laugh. Additionally, another child in the home would hit other children with plastic bats.

"Whenever a DHS worker would come," the child had told her mother, "the punishment would stop until he left and it would resume when this worker left."

The intake worker informed the mother that, although the issues she identified were concerning, the ultimate decision was to reject the intake. We found no evidence the information was referred to the daycare licensing worker, or that it was shared with the field worker whose April 10, 2014, assessment was closed the same day.

May 2014 staffing

While information on the May 7 report was not shared with the field worker, it was shared with the DHS foster care licensing unit the same day the report was made. Social work administrator Mike McInroy directed ongoing-services worker Hoffman to interview the children and be specific about "asking the questions surrounding the intake. For example, using food as punishment, not feeding them, etc." McInroy also requested that Hoffman contact the service providers, which would have included Messersmith.

According to an email dated May 12, Hoffman emailed her supervisor, Mark Chappelle, and stated that she had interviewed two of the Miller foster care children at their respective schools. Chappelle requested that she cover the concerns raised in the allegation.

When we interviewed Hoffman, she stated that she did not cover the specific issues and had not known to do so until after she had visited the children. Hoffman said she only asked whether the children were getting enough to eat, what time they went to bed, what they did every day, and when they showered. We found no evidence that Hoffman had contacted the service providers, as directed by SWA McInroy.

Chappelle expressed surprise to our office at Hoffman's response: "Marcia was a pretty straight arrow. You tell her to do something, and she did it." Chappelle stated that he was unaware that Hoffman had not complied with his request.

June 12, 2014, bruising

When FSRP worker Shelby Messersmith visited the Miller children at their biological mother's home on June 12, 2014, she documented bruising on the youngest child. Her report stated:

> **[The mother] showed FC**[2] **a series of bruises that were on [the child]**. … [The child] kept saying, 'don't hurt me, don't hurt me.' as she was crying. FC advised [the mother] to talk with Marc and Misty about the bruises to see what they had to say. **[The child] communicated to FC that one of Marc and Misty's daughter's hurts her. FC talked to Marc and Misty about it and they stated that their daughter is very caring and would not hurt anyone**. [The mother] talked to Marc and Misty about it and they were defensive and stated that they were not going there with her and they didn't know [the child] had bruises on her. FC made sure that all parties were aware of this situation. (Emphasis added.)

Messersmith believed there was a strong chance that the bruising had been inflicted by the Rays. She told us that the bruising was up the child's back and thigh, not in common "play areas" such as a child's knee.

Messersmith stated that she went to her Mid-Iowa supervisor, Susan Smalley, regarding the bruising on the child, but was told that she could not make a child abuse report to DHS.

Messersmith told us that she also raised this concern with ongoing-services worker Hoffman; however, she never felt like she was taken seriously. Although Hoffman did not document her conversation with Messersmith in any case notes that we received, she did reference Messersmith's allegations in conversation notes she had with the mother's attorney. The attorney's June 16, 2014, email read:

> We NEED to get the children out of Misty and Marks (sic) this week!!! I had a long talk with Shelby [Messersmith]. [The child] has unexplained bruising. … I will make closing this daycare down if they aren't removed. ... Mark (sic) and (Misty) are emotionally abusing and physically neglecting [the] children. I don't doubt it for a minute.

On June 17, Hoffman documented her call with the attorney:

> She wants the children removed and returned to [the biological mother]; **Shelby told her about the bruises and Shelby's supervisor would not let her call it in to CPA**. … discussed that the daycare worker, CPA, this worker had all been to the home or interviewed the children and there was no evidence or abuse or neglect in the home. (Emphasis added.)

[2]"FC" refers to FSRP worker, Messersmith.

On June 19, Hoffman documented in a case note the following conversation with the biological mother's attorney:

> Informed her DHS would not be moving the children from the Ray foster home; informed her Shelby asked Misty about the bruises on [the child]; **she then talked with her supervisor and the concern will not be called into CPA Intake**. (Emphasis added.)

We found no indication that Hoffman visited the children after the concerns were raised on June 12. Her case notes document a visit on June 4, 2014, and the next visit did not occur until August 1, 2014.

Following the mid-June bruising concern, DHS and Mid-Iowa coordinated a meeting that was attended by Chappelle, Smalley, and Messersmith. Smalley mentioned the meeting in an email to Mid-Iowa Family Preservation and Stabilization Services Director Lori Mozena on June 18, 2014:

> Talked with Mark Chappelle this morning. We are going to go ahead and meet on Friday to discuss the situation. He agreed that a '**public flogging**' was not necessary but that Shelby did need to hear from the DHS end as well as the position she put herself because of this situation. He's not requesting a new worker and will support whatever we choose to do staffing wise. Now just keep your fingers crossed that mom's attorney let's the situation drop and doesn't push it in court…..! (Emphasis added.)

Messersmith told us that she was completely blindsided by the meeting. She believed that she would be able to address the concerns that she had with the family, but instead she was verbally reprimanded for raising the concerns. Messersmith stated that the message from the meeting was clear: "Do your visits and shut up."

Messersmith left her job as an FSRP services worker with Mid-Iowa in July 2014, shortly after her meeting with Chappelle and Smalley. Messersmith stated she thought she was doing good by raising the concerns, but she "wasn't doing good anymore," so she had to go. She told us that she felt "defeated."

July 5, 2014, accepted intake and assessment (not confirmed)

DHS received a child abuse report on July 5, 2014, involving the same child Messersmith had raised concerns about three weeks earlier. The call came from the child's biological mother, who claimed that Marc and Misty "spanked, smacked, slapped" the 2-year old, which resulted in bruising. The report was accepted for an assessment. The field worker who handled the intake call conducted the initial home visit the day after the report was made.

The field worker observed the alleged child victim at the Rays' and concluded that there were "no visible injuries consistent with the allegation reported." It was documented that there was a "faint scratch on her lower back from her pull-ups," which was the explanation the Rays provided. A second field worker visited the child's biological mother's home on July 11 to

check on the child and her siblings. He documented that there were "no visible injuries on the children." When the children were interviewed, they reported that they liked the Rays and indicated that they were not physically disciplined.

The field worker also contacted ongoing-services worker Hoffman, who shared that she saw the children regularly and they had reported to her on several occasions that they liked staying at the Rays' home.

Hoffman received an email from Misty on July 7, 2014, regarding the initial home visit on July 6. Misty stated in the email:

> We got a visit from a CPS worker yesterday about [the child]. It was turned in that we were spanking her for not using the potty and if she has accidents in her pants. And that she was covered in bruises. When the gentleman spoke to all three kids they told them the only type of discipline that we use here is time outs and when he checked her for bruises there was only one tiny bruise on her knee and a small almost gone bruise right behind her knee. …
>
> There is a spot on [the child's] back that is yellow, she has had this same spot since May. **It was the spot she said [the child] got at respite and has also told Shelby that she got at our house. It is not a bruise, but some sort of skin discoloration**. The worker left with no concerns. (Emphasis added.)

According to Hoffman, she did not share this information with the field worker, even though it appears that the information was received prior to his contact with Hoffman.

Hoffman could not recall for us whether she had mentioned Messersmith's prior allegations involving the child's bruises, and the child abuse assessment does not indicate that either of the field workers contacted Messersmith. Ultimately, the physical-abuse allegation was determined to be not confirmed.

The Miller children remained in the Rays' foster home for an additional 23 days. The children were reunified with their biological mother on July 28, 2014. This was the last time the Rays had foster children placed in the home.

On July 30, 2014, DHS Service Area Manager (SAM) Pat Penning sent an email to SWA Mike McInroy asking that he take a closer look at the family because "The number of assessments and rejected intakes is concerning." Penning requested that McInroy review the following information: "Why do they keep getting referred? Who are the reporters? Is there a pattern? What are we missing?"

There is no indication from DHS records that any further discussions on the issue took place for nearly two months. Penning wrote an email to McInroy on September 30, 2014, that she had not received McInroy's findings of the family and asked that he bring the information to their next one-on-one meeting. That was the last communication between these two officials regarding the Ray family.

November 25, 2014, rejected intake

DHS received a child abuse report regarding one of Sabrina's sisters (then age 10) on November 25, 2014, from an anonymous reporter who had previously taken her daughter to the Rays' daycare. The daughter told her that Misty would hit Sabrina's sister and always told the daughter to close her eyes. It was alleged that child victim had a bruise on her neck when the caller saw her.

The reporter also stated that Sabrina and her sister were "always standing" in the home, and on one occasion, the reporter saw the alleged child victim was standing for a lengthy period of time. In addition, the reporter shared concerns about the child's weight, telling the intake worker that she is "very, very, very thin, she's very small … I wonder if she's not eating right."

The intake document identified the allegation as "Physical Abuse." According to the intake report, SWS Mike Allison reviewed the intake and made the final decision to reject it.

ANALYSIS AND CONCLUSIONS OF 2014 EVENTS

Many significant events occurred between April and November 2014. During that seven-month period, DHS was actively involved with the family through the receipt of five child abuse reports (two accepted intakes and three rejected intakes), a daycare licensing complaint, foster care licensing and ongoing services, and FSRP services.

Keeping foster children in the home

Regarding the decision to place a "hold" on the foster care license, we conclude that the initial decision following the April 10, 2014, accepted intake was appropriate. We do question, however, DHS's decision to keep the Miller children in the Ray home after it had received three additional child abuse reports about the Rays, two of which involved the Miller children.

There is no formal policy regarding the practice of placing a foster care family on "hold." Additionally, there is no articulated procedure concerning if and when foster care children should be removed while there is a hold in place. In this instance, DHS determined on April 11, 2014, that a "hold" would be enacted for *future* placements, but the Millers would remain with the Rays.

We believe DHS would benefit greatly by creating a policy that details the protocol for placing a foster family on "hold." Further, the protocol for handling the children currently placed in the home should be examined. In this case, DHS debated at an April 11, 2014, staffing whether the Miller children should be removed from the Rays' home. We do not believe the question should have been *if* the children should be removed, but *when*. If DHS does not trust the foster home for future placements, there should be no question whether the foster home should be trusted for current placements. Logistically, we understand that it may have taken time to identify a new placement for the children, and removal may not have happened immediately. However, there is no question that as soon as the decision was made to place the home on "hold," DHS should have immediately begun the process to consider alternative placement options. Keeping the children in the home should never have been an option.

While we concede that placing children in foster care creates a disruption in their lives, it is equally troubling for children be placed in a foster home in which there is a continual concern for the well-being of the children. We believe that the risk in the Ray home was too high.

In short, we found the decision to keep the Millers in the Ray home following the "hold" was unacceptable, and the decision to keep the Millers in the Ray home as new concerns and child abuse reports continued to be filed was unfathomable.

We did not find there was a basis to revoke the Rays' foster care license. However, we believe sufficient grounds existed at least later in 2014 to formally suspend their license.

We do not believe any person has a *right* to hold a foster care license. DHS is granted the authority to dictate who should have a foster care license and who should not. If events occur to put into question whether foster parents can appropriately care for foster children, or whether the children placed in the home are safe, then DHS should have the ability to suspend the foster care license and remove any children currently placed in the home. Given existing policies, however, it appears that the conditions for suspension are much too difficult to achieve so DHS instead placed a "hold" on the family, and unfortunately – as was the case with the Millers – foster care children are the ones who ultimately suffer.

DHS should review its standards to suspend a foster care license, such that the focus is on the best interest of the children.

Decision to reject intakes

It is our opinion that the April 24, 2014, intake should not have been rejected. Though the information from the intake was forwarded to the DHS ongoing-services worker, we do not believe that was sufficient. Instead, an allegation that a child is being forced to swallow, or spit up *and eat* his vomit should have warranted a child abuse investigation on its own.

In addition, we do not agree with DHS's determination following Sabrina's death that the May 7, 2014, intake was appropriately rejected at that time. Aside from the developing patterns of alleged abuse, the claims about a foster child being forced to bite her sister and being forced to stand over a cold vent for long periods of time despite a medical condition, stood on their own for an accepted intake.

Similarly, by the November 25, 2014, intake a clear pattern of abuse allegations was established. An allegation that the Rays had directed a child to close her eyes while another child was struck, in combination with observed bruising, warranted an accepted intake even under the standards employed in 2014.

Notifications to daycare licensing

We concluded that daycare licensing staff did not receive notice of *any* child abuse report made to DHS involving the Rays with the exception of the April 10, 2014, accepted intake.

Failures by the ongoing worker

Although monthly visits with the Rays could have been completed by either Hoffman or the FSRP services provider, we found no supporting documentation that Hoffman visited the Rays in July 2014; all the while, Messersmith was refused entry to the Ray home. Additionally, according to DHS records, it appears that a number of the visits occurred at the biological mother's residence, and not at the Ray home, as required under the foster family placement contract.

We also found that Hoffman failed to review the intakes and assessments that occurred during the placement of the foster care children under her watch, which prevented her from ensuring the safety of the foster care children. Hoffman's reliance on other DHS employees having oversight of the Rays was misplaced. Hoffman failed to understand that the majority of the others involved with the family were counting on *her* to have eyes and ears on the family.

DHS administration and foster care licensing took affirmative steps to formulate a plan following the rejected May 7, 2014, intake call about a former foster care child. That placed the responsibility on Hoffman to question the current foster children on the specific allegations and to ensure their safety. We found this plan was sound, but unfortunately, it was not carried out appropriately by Hoffman when she failed to ask the children specific questions relating to the rejected intake or contact the service providers.

Additionally, Hoffman could not recall seeing the adopted children beyond perhaps on one occasion, when she was introduced to one of the adopted daughters. This means that Hoffman's report that she had never seen any withholding of food or maltreatment of Sabrina or her sisters was misleading.

Regarding the July 5, 2014, accepted intake and unfounded assessment, we conclude that Hoffman failed to provide important information to the field worker handling the assessment. We believe this failure significantly impacted the field worker's investigation.

Failures of ongoing worker's supervisor

We have concerns about Chappelle's actions – and inactions – in this case. First, we question Chappelle's rationale for keeping the Miller children in the Ray home when the "hold" was placed following the April 10, 2014, accepted intake and staffing. Chappelle explained to us that DHS had intended to keep an eye on the children to ensure their safety in the home. However, this rationale seems seriously flawed. DHS did not believe other children should be placed in the home, but the Miller children could remain; that the Millers were somehow impervious to the safety concerns associated with other children who would be placed in the home. Based on the events that followed, the Millers were just as vulnerable as any prospective foster child.

Additionally, as Hoffman's supervisor, Chappelle was in charge of ensuring Hoffman was handling her cases appropriately and in compliance with DHS policies and practices. What we learned, however, was that Chappelle was initially unaware that Hoffman had not fulfilled the

requests handed down by DHS administration following the May 7, 2014, rejected intake and staffing.

Interference with making a child abuse report

Iowa Code section 232.70 states: "The employer or supervisor of a person who is mandatory or permissive reporter shall not apply a policy, work rule, or other requirement that interferes with the person making a report of child abuse." If Mid-Iowa's practice of requiring FSRP workers to confer with a supervisor prior to making a child abuse report results in a report being suppressed, we firmly believe that is a violation of law.

Messersmith should have been permitted to make the child abuse report concerning the bruising she saw on one of the Miller children during her visit on June 12, 2014. Though Smalley does not recall whether Messersmith raised concerns of the bruising to her, we found there was sufficient corroborating evidence to suggest that this discussion did occur and resulted in the decision that Messersmith would not make a report to DHS. Hoffman's documentation in her case notes specifically supports this finding.

We believe there was sufficient information to warrant a report to DHS based on the observations made by Messersmith during her visit.

DHS policy indicates that for a report to constitute an allegation of physical abuse, there must be "damage to any bodily tissue that would require a healing process or there is damage to the body that results in the death of a child." An accepted intake will lead to a child abuse assessment when it involves any non-accidental physical injury, or an injury that does not match the history given for it, that is suffered by a child as a result of the acts or omissions of a person responsible for the care of the child.

We also believe that some of the pushback from Smalley could have stemmed from Chappelle's concerns about Messersmith's handling of the FSRP case with the Millers. Smalley recalled Chapelle raising the issue about Messersmith going around DHS to the mother's attorney; this could have caused Smalley to impose a tighter rein on Messersmith's handling of the case.

Despite the resistance from Smalley, Messersmith stated that the CEO of Mid-Iowa met with her and was supportive of her handling of the case.

The Ombudsman recommends that DHS:

2. **Create a policy to articulate the protocol for placing a foster family on "hold," and ensure that foster care children placed with a family on "hold" status are removed as soon as possible.**

3. **Review the standards necessary to suspend a foster care license, such that the focus is placed on the best interests of the children placed in the home and whether those children are in a safe place.**

The Ombudsman recommends that Mid-Iowa:

1. **Review its practice and policy that requires consultation between FSRP services workers and supervisors to ensure non-interference with reporting requirements, consistent with Iowa Code section 232.70.**

NOVEMBER 2, 2015, ACCEPTED INTAKE AND FAMILY ASSESSMENT

A Wal-Mart customer made a child abuse report to DHS on November 2, 2015, after seeing the Ray family, including Sabrina and her sisters, at the store. The customer stated that the children appeared "listless and ill," and two of the children looked emaciated. She described that one child who appeared to be 12 years old "was complete skin and bones" and "looked anorexic."

A field worker conducted an unannounced home visit on the same day the report was made. The three girls said that they were fed regularly and ate as much as everyone else in the home. The field worker wrote that Sabrina "is very thin," but Sabrina explained that she had always been thin because she had a high metabolism.

The field worker contacted the children's medical provider for records and was told the children were seen on an as-needed basis for illnesses and checkups. The family assessment summary also noted that "Sabrina [and her sisters] were home schooled, which was overseen by the Home School Department of the Perry School system."

Ultimately, the field worker and her supervisor determined that the children were safe.

ANALYSIS AND CONCLUSIONS OF NOVEMBER 2015 ASSESSMENT

The November 2, 2015, assessment was the last time that DHS had eyes and ears on Sabrina prior to her death. In both the Finn and Ray cases, the children were coached to provide certain information to DHS. Similarly, in both cases, the field worker failed to confirm malnutrition after visional inspection.

We asked for clarification on the information that the field worker received from the children's medical records request. She stated that she placed a call to the children's medical provider during the assessment but did not receive a call back until after the family assessment was closed. We learned through a DHS report after Sabrina's death that aside from an eye exam in 2014, she had not been seen by medical provider since 2012.

Additionally, we asked the field worker if she had received adequate training through DHS on determining whether a child is malnourished. She replied that she had not. In fact, she had not received *any* training on how to identify malnourishment.

We believe that, in addition to receiving training on identifying malnourishment, DHS field workers would benefit greatly if they had medical professionals they could consult in such cases. One option DHS should consider is implementing a medical-related assistance service similar to the Service Help Desk that provides explanations and answers to DHS staff throughout the state. An assistance service, staffed fulltime by medical professionals, could operate as a resource for

DHS workers who have questions regarding a medical-related issue both when conducting child abuse assessments and when developing safety plans.

Another option would be to develop a contractual relationship with Iowa's county public health agencies that employ nurses or contract for nursing services. This would allow a local nurse to actually visit a home when necessary and review medical records. This is not a novel idea. We have been told that juvenile courts in Iowa have ordered county nurses' involvement in some court cases. We have also found other county and state child welfare agencies that employ nurses. For example, Mercer County [Pennsylvania] Children and Youth Services investigates child abuse reports and has employed a full-time nurse for over a decade. The nurse is responsible for reaching out to doctors and interpreting their reports. He or she goes to homes and conducts weight checks and clarifies the medical treatment requirements that should be included in a safety plan. A supervisor at Mercer County described their nurse to our office as a "huge benefit" to their case workers and for case management.

The Ombudsman recommends that DHS:

4. **Include training for workers to help them identify signs of malnourishment, to include when it is necessary to take a child to a physician for evaluation.**

5. **Utilize readily-available medical professionals for consultation on cases, including cases of alleged malnourishment. This could be accomplished by:**

    a. **Employing or contracting with medical professionals who are available to staff cases of malnourishment;**

    b. **Establishing a Medical Help Desk similar to the Service Help Desk; or**

    c. **Contracting with Iowa's county public health agencies.**

DAYCARE LICENSING COMPLIANCE VISITS: 2015-2016

Child-development homes are required to have annual unannounced compliance visits. The last two visits at the Rays' daycare occurred on December 4, 2015, and December 1, 2016.

During the first visit, the worker found the daycare to be out of compliance for not having the phone numbers for police, fire, ambulance, and poison information posted by the phone; not having the numbers for each child's parent, physician, and a responsible person accessible by the phone; and not having the emergency parent contact information in travel vehicles.

It was also noted that the Rays' first-aid kit did not contain disposable tweezers, nor did records include physical examination reports for all children, or immunization records for one child. Certain training and certification information was also found to be out of compliance.

Though there were certain areas out of compliance, the worker found that the corrections did not require a re-check or follow-up visit. She requested that the Rays make the corrections and self-certify they had done so to DHS by January 19, 2016.

The next home-compliance visit was conducted almost one year later on December 1, 2016. The daycare did not have documentation of physical examination records for nine children, or immunization records for six children. The daycare also was not tracking hours of substitute employees.

The daycare licensing worker again determined that the issues did not require a recheck or follow-up visit, but needed to be corrected by February 6, 2017. In a December 15, 2016, letter to Misty following the visit, it was noted that she would "verify corrections have been made during the next annual compliance check."

The December 1, 2016, home-compliance visit was the last time DHS was in the home prior to Sabrina's death 162 days later, on May 12, 2017.

ANALYSIS AND CONCLUSIONS OF DAYCARE LICENSING, 2015-2016

In the 2015 and 2016 home-compliance visits, there was information missing from the child files, including physical examination records and immunization records. Considering the number of records and information contained in each child's file, it is difficult to say whether the missing information qualified as an "extensive failure to maintain child file documentation" that would require a re-check.

Regardless, a re-check should have been required after the 2016 visit found that child files were still missing physical examination reports and immunization records. The policy specifies that "Failure to be in compliance with areas that were out of compliance at time of the previous annual inspection" *requires* a follow-up visit.

We also considered whether the DHS worker followed policy by observing all the rooms in the Rays' home during the daycare compliance visit. Under a heading labeled "Indoors," DHS policy states that "all rooms should be observed for compliance. If a room is inaccessible, ask for entry. If entry is denied, document and talk with your supervisor."

We believe this requirement was specifically relevant to the case, based on the condition of the girls' bedroom at the time of Sabrina's death. If such deplorable conditions – evidence of a lock and alarm on the bedroom door, boarded up windows, no mattresses, toddler potties on the floor – existed at the time of the home-compliance visits, this certainly would have raised red flags to the DHS worker.

However, when we interviewed the licensing worker, she stated that she examined only the lower level of the home where the main areas of the daycare were found. The worker explained that her typical practice was to observe the rooms in the home that are relevant to daycare, unless she has suspicions of something going on. The daycare licensing worker told us that the home was "clean and appropriate," and she did not recall specifically if she saw Sabrina during the December 1, 2016, home-compliance visit.

Based on the description of the scene on May 12, 2017, the Perry law enforcement officers found Sabrina deceased in a downstairs bedroom, which was located off the dining room and away

from main daycare play area. The information we received does not suggest that this bedroom was examined during the home-compliance visit.

We asked DHS for clarification on when daycare licensing staff were given instructions on the requirement to observe all the rooms in the home. We were told that DHS policy was updated in September 2016 to include the requirement, but staff were actually informed of the requirement prior to the formal change to policy, as well as during a training course. The daycare licensing worker who conducted the last two compliance visits stated, however, that she did not recall receiving training to observe all of the rooms in the home for compliance until June 2017, a month after Sabrina died.

A daycare licensing worker also shared concerns with our office regarding day care licensing staffing levels, stating that one of the biggest obstacles in fulfilling the duties of a day care licensing worker is not having enough staff to do the job.

The Ombudsman recommends that DHS:

6. **Provide additional training to all daycare licensing staff to ensure that workers know when a re-check of a home is required due to non-compliance.**

7. **Include in the checklist for child-development home registration a specific box for observing all of the rooms in the home for compliance.**

8. **Evaluate the adequacy of daycare licensing staffing levels. If DHS concludes that daycare licensing is not sufficiently staffed, it should ask the Council on Human Services to make any required personnel and budgetary requests to the Governor and General Assembly.**

COMMUNICATIONS BETWEEN DHS UNITS

This report has illustrated that DHS staff in separate units of the agency communicated inefficiently or not at all about the child abuse reports against the Rays. Though we have already touched on this topic, we believe a broader review of the communications and staffings within DHS prior to Sabrina's death on May 12, 2017, warrants its own findings and conclusions.

2010

Following the 2010 assessments of child abuse allegations, DHS voiced enough concerns about the Rays, that it was determined by the Western Service Area a corrective action plan should be implemented. Shortly after the final assessment was completed in 2010, however, Marc and Misty had moved back to Perry, out of the Western Service Area. It was then recommended to the Des Moines Service Area to implement and monitor a corrective action plan for the family. It is our understanding that this did not occur.

2014

DHS was most heavily involved with the Ray family in 2014. As such, it was the year that required the greatest need for intra-department communication.

After the first child abuse report in April, a formal staffing had occurred among various DHS staff where it was decided that the foster children in the home children would not be removed. Regardless, direction was given that the home would not be used for foster care in the future.

Another formal staffing occurred a few weeks later between daycare licensing, ongoing services, and social work administrator (SWA) Mike McInroy following another child abuse report. McInroy provided direction to have the ongoing worker interview the current foster care children about the specific concerns identified in the rejected intake, and to touch base with service providers. Those directives were not followed.

In June, the DHS ongoing worker was notified that one of the foster care children had suspicious bruising believed to have been inflicted by the Rays. We received no information to suggest that this was relayed to foster care licensing.

The following month, a formal child abuse report was made about the bruising on the foster child. The field worker contacted the ongoing-services worker, who shared that she saw the children regularly and had no concerns – even though weeks prior she had been notified of the suspicious bruising. Additionally, the field worker did not contact the FSRP services worker, Shelby Messersmith, who, just weeks earlier had raised concerns about the bruising.

Several weeks after this series of reports was received, SAM Penning sent an email to SWA McInroy asking that McInroy take a closer look at the Rays. Penning requested that McInroy review why the family kept getting referred, who the reporters were, whether there was a pattern, and what was missing. The next email exchange that we received is dated nearly two months later. It indicates that Penning had not received McInroy's findings on the family, and she asked that the information be brought to their next one-on-one meeting.

No further email exchanges on this subject were provided by DHS, and Penning could not tell us what she discussed with McInroy or what the outcome of this meeting was.

The next child abuse report was received on November 25, 2014, and another was submitted nearly a year later on November 2, 2015. There is no indication that foster care licensing received notice of these reports, even though the Rays still had a foster care license. Likewise, it does not appear that any further staffings on the matter occurred between any employees within DHS.

One interviewee suggested that no further staffing occurred on the family because the agency already "decided how things were going to roll," meaning no more foster care children would be placed in the home. We asked whether foster care licensing staff would even have received notice of the November 2014 and November 2015 child abuse reports, since there were no longer foster care children in the home. The interviewee responded: "It would be difficult given all of

the discussion with the Rays, that foster care licensing would not have found out one way or another."

Daycare licensing

DHS Employees' Manual indicates that "When it is alleged that child abuse has occurred in a child development home, the protective service worker will immediately inform the child care registration worker."

We received no information to suggest that a referral was made to daycare licensing staff for any of the 11 child abuse reports received between 2010 and 2015, with the exception of the April 10, 2014, intake.

We asked how former DHS supervisor Mark Chappelle actually received referrals on child abuse reports. Chappelle could not recall specifically, but remembered that he did receive some sort of notification of a report being made. Asked whether he believed the problem stemmed from referrals not being made to daycare licensing, he stated, "I would like to think so because I'd like to think I wouldn't let something like that get by me."

Lack of internal investigation following Sabrina's death

We are also concerned about the lack of internal investigation by DHS following Sabrina's death. DHS provided no explanation as to why a formal review had not been completed. Considering the extent of DHS's involvement with the family and the tragic outcomes, it seems that such a review would have been in order.

Chappelle acknowledged that he was surprised no internal investigation took place: "Usually after something like that, we would want to talk to everybody who touched this in the last five years."

We believe an internal review could have greatly benefited DHS to shed light on mistakes and spur discussion on future improvements. Other states see the value in reviewing child deaths. Oregon, for example, implemented a new law earlier this year that creates Critical Incident Review Teams in cases where the death of a child may have been from child abuse. The team is required to submit a written report to the Oregon Department of Human Services no later than the 100th day following the date they were assigned the case. There is a list of criteria the report must include. Unless releasing the information will compromise a criminal investigation, specific portions of the report are then published on the agency's website.

ANALYSIS AND CONCLUSIONS OF COMMUNICATIONS BETWEEN DHS UNITS

The Rays had a licensed daycare that involved 112 children in and out of the home over the course of 13 years. The Rays were licensed foster care parents for nearly 10 years and accepted a total of 23 placements. The Rays adopted four children from foster care. For all of these reasons, the Rays were subject to oversight by DHS.

DHS was further involved with the family due to numerous child abuse reports – 11 within a five-year span. To the extent possible, there were plenty of official eyes and ears on this family.

We cannot dispute the notion that Marc and Misty Ray were likely skilled manipulators who knew how to work the system. With two parents involved in the day-to-day home life, it would have been very easy to stage the scene to make it appear nothing was awry, even when a DHS worker made an unannounced visit.

Testimony from the surviving children confirmed what several reporters suspected – that the Rays had coached the children in their home to provide acceptable answers to DHS's questions. DHS did not receive honest answers during its investigations at the home into allegations of physical abuse and "denial of critical care."

How does DHS protect children when allegations of abuse have not been proven? The answer lies in active and productive communications among child welfare workers who have regular interactions with families. These communications should include a broad overview of what the specific concerns are with the family, and how those concerns can be addressed.

Efforts were made to raise concerns among different DHS units about the Rays, particularly between foster care licensing, ongoing services, and field workers (when they were involved). When it came down to it, there was not sufficient communication among these DHS units. We found that daycare licensing staff was either not receiving the referrals, or the home checks were generally not being completed. Based on the testimony to our office, we question whether there is sufficient protocol to ensure referrals are made.

We also found that DHS failed to include the FSRP services worker, Messersmith, in its staffings. Messersmith was not only familiar with the home, she also had raised numerous red flags throughout her time with the Rays. DHS not only dismissed Messersmith's concerns, but, along with her supervisor at Mid-Iowa, actively discouraged her from speaking up.

The lack of an internal investigation by DHS is unacceptable. Sabrina, her surviving siblings, the foster care children, the daycare children, and all the children subject to abuse by Marc and Misty and others in the Ray household, deserved at least this. Had the Ombudsman not initiated an investigation of Sabrina's death, DHS's shortcomings and failures would have gone undiscovered to both the agency and the public.

DHS needs to develop a protocol for investigating the death of children, especially in cases where DHS has had some involvement.

We have no doubt that making the system better is everyone's goal. This is best achieved through greater transparency.

The Ombudsman recommends that DHS:

9. **Develop in policy a protocol for daycare licensing workers to be notified of the child abuse reports received (both accepted and rejected) whenever a daycare home is**

involved. If there is already a protocol in place, the Ombudsman recommends that DHS evaluate the effectiveness of the protocol.

10. **Initiate a tracking procedure to ensure that child abuse report referrals are made to daycare licensing staff, and that subsequent home checks are being completed as required by policy.**

11. **Develop an internal tracking and/or notification system to ensure that each unit of DHS that is involved with a family is appropriately communicating the others.**

12. **Create a provision in policy requiring that contracted service workers be included in internal staffings and reviews, and requiring that field workers handling assessments communicate with any contracted service workers as collateral witnesses.**

13. **Create protocol in policy requiring an internal review by a designated team and a written report in situations where DHS reasonably believes the death of a child under the age of 18 was the result of child abuse and:**

    a) **The child was in the custody of DHS at the time of death;**

    b) **The child, the child's sibling, or any other child living in the household with the child was the subject of a child abuse assessment within the 12 months preceding the fatality;**

    c) **The child, the child's sibling or any other child living in the household with the child had a pending child welfare or adoption case with DHS within 12 months preceding the fatality;**

    d) **The child, the child's sibling or any other child living in the household with the child was the subject of a child abuse report made to DHS or law enforcement within the 12 months preceding the fatality, whether or not the report was rejected at intake; or**

    e) **The household where the child lived is/was a licensed foster home or provided daycare services.**

    The team's final report shall include a description of any concerns the team has regarding actions taken or not taken by DHS or its contractors in the case.

    The final report shall also include any recommendations for improvements in administration and oversight, as well as training and intervention.

AGENCY AND PERSONNEL RESPONSES TO THE REPORT AND OMBUDSMAN COMMENT

The Ombudsman received responses from DHS, Mid-Iowa, and former DHS employee Mark Chapelle.

DHS

DHS accepted 10 of our 13 recommendations. DHS did not accept our recommendations to amend it records retention schedule for child abuse intakes, remove foster children as soon as possible when a home is placed on "hold" status, and create a policy requiring DHS to conduct an internal review in the event of a child death.

We considered DHS's response and stand behind our recommendations as proposed.

Mid-Iowa Family Therapy Clinic

Mid-Iowa requested several sections of the report be modified, most significantly to indicate that former employee Messersmith failed to comply with the company's internal reporting system.

We considered this request and determined not to modify the report. We found that Messersmith took reasonable steps to raise concerns about the Ray family with her supervisor, and the management team at Mid-Iowa was aware of her concerns and reports to DHS. We did not find any compelling reason to change other portions of the report.

Mark Chappelle

Chappelle provided his comments to the report and requested that we clarify that he was not solely responsible for keeping the foster children in the Ray home during the "hold." We believe the report is clear that the decision to keep the children in place was made by a number of individuals who participated in a staffing. Therefore, no change in the report was necessary.

Report Preface

ROLE OF THE OMBUDSMAN

The Office of Ombudsman (Ombudsman) is an independent and impartial agency in the legislative branch of Iowa state government. The Ombudsman investigates complaints against most Iowa state and local government agencies. The Ombudsman has jurisdiction to investigate any administrative action of any person providing child welfare or juvenile justice services under contract with an agency that is subject to investigation by the Ombudsman. The governor, legislators, judges, and their staffs fall outside the Ombudsman's jurisdiction. The Ombudsman's powers and duties are defined in Iowa Code chapter 2C.

In response to a complaint or on the Ombudsman's own motion, the Ombudsman determines whether an agency's actions were unlawful, contrary to policy, unreasonable, unfair, oppressive, or otherwise objectionable. The Ombudsman may make recommendations to the agency and other appropriate officials to correct a problem or to improve government policies, practices, or procedures. If the Ombudsman determines that a public official has acted in a manner warranting criminal or disciplinary proceedings, the Ombudsman may refer the matter to the appropriate authorities.

If the Ombudsman decides to publish a report of the investigative findings, conclusions, and recommendations, and the report is critical of an agency, official or employee, they are given an opportunity to reply to the report, and the unedited reply is attached to the report.

PURPOSE OF THE REPORT

This report presents our investigative findings and conclusions on the performance of the Iowa Department of Human Services (DHS) to properly license, interact with, and oversee Marc and Misty Ray. The Rays' oldest adopted child, Sabrina, was starved to death under their care in 2017. DHS was charged with fulfilling a host of responsibilities with the Rays after the agency permitted the couple to serve as foster parents, adopt four children, and run a daycare out of their Perry home. As part of our investigation, we also examined the role of the Mid-Iowa Family Therapy Clinic (Mid-Iowa), which was contracted by DHS to provide Family, Safety, Risk, and Permanency (FSRP) services to three children who were placed in foster care with the Rays. Throughout this report, we reach conclusions on several of DHS's general practices and policies, and we present 14 recommendations to strengthen Iowa's child-welfare programs.

It should be noted that we found many actions or decisions by DHS and Mid-Iowa workers to be appropriate. However, given the Ombudsman's statutory role and responsibility, this report focuses on instances of non-compliance with laws, rules, or policies and procedures. This report also examines policies, procedures, and practices that could be improved.

The investigation took an extended amount of time due to the complexity of the facts and the many roles DHS and Mid-Iowa had with the family. Of particular note, we made a significant effort to identify all issues and concerns with DHS's handling of child abuse reports, foster care licensing, ongoing-services, and daycare licensing, while evaluating whether the divisions within

the agency had sufficient communication when concerns about the family were presented.

INVESTIGATIVE PROCESS

The Ombudsman self-initiated this investigation on May 25, 2017. The Ombudsman assigned the investigation to the following staff: Assistant Ombudsman Angela Long, the team leader; Assistant Ombudsman Jacob Hainline, child welfare specialist; Jeff Burnham, Senior Assistant Ombudsman; and former Assistant Ombudsman Barb Van Allen. For reference purposes in this report, actions taken by members of the investigative team are ascribed to the Ombudsman.

Documents and records

Our findings and analysis rely on the following documentary and testimonial evidence obtained by our office:

- Iowa law and DHS administrative rules (Iowa Administrative Code).
- DHS policies and procedures.
- DHS child protective intake records and assessment records involving the Ray family. This included audio recordings from phone conversations between reporters and intake workers.
- DHS foster care licensing and ongoing-services records involving the Ray family.
- DHS daycare-licensing records involving the Ray family.
- Law enforcement records.
- A summary prepared by DHS for a briefing with Iowa legislators entitled "Confidential Briefing."[3]
- The Ombudsman's public report issued in 2000 concerning the death of Shelby Duis.[4]
- The Ombudsman's public report issued in 2020 concerning the death of Natalie Finn.[5]

[3] DHS, *Confidential Briefing* (2017). DHS provided this document to us which is essentially a timeline of DHS's involvement with the Ray family. The Confidential Briefing also provides an overview of the adoptive subsidies, foster care subsidies, and child-care assistance payments made to the Ray home between 2006 and 2017. In sum, the Rays were paid a total of $640,069.95.

[4] The Ombudsman's investigative report on the Duis case, "Investigation of the Department of Human Services' handling of allegations of child abuse concerning Shelby Duis," is available at https://www.legis.iowa.gov/docs/publications/CI/678.pdf.

[5] Natalie Finn died on October 25, 2016, after medical rescue personnel found her unresponsive and not breathing in her home. Her cause of death was later determined to be emaciation due to denial of critical care.
We first heard of Natalie Finn on December 8, 2016, when media reports alleged that DHS had failed to investigate reports of a starving child prior to her death. We issued a notice of investigation to DHS that same day, and requested all child abuse intakes and assessments involving the Finn family.
Our investigative report on the Finn case, "A Tragedy of Errors: An Investigation of the Death of Natalie Finn," was released on February 17, 2020. The report made 14 recommendations to DHS to improve policies and procedures.

Interviews

During the investigation, we interviewed and took sworn testimony from multiple witnesses, including:

- Seven current and former DHS employees:
  - An intake worker who received a child abuse report about the Ray family.
  - A field worker who was assigned to investigate two accepted child abuse reports.
  - A daycare licensing worker who handled the last two compliance home visits with the Rays in 2015 and 2016.
  - A prevention program manager.
  - A former ongoing-services worker who was assigned the handling of services for a family placed in foster care with the Rays.
  - A former Social Work Supervisor (SWS) who oversaw the handling of the ongoing-services worker and daycare licensing.
  - A former Service Area Manager (SAM) for the Des Moines Service Area.
- Two current and former employees of Mid-Iowa:
  - A former Family, Safety, Risk, and Permanency (FSRP) services worker who handled cases with foster care children placed in the Ray home.
  - The director for FSRP services (who formerly was a supervisor of FSRP workers, including the former FSRP worker we interviewed).
- Others:
  - A law enforcement official involved in the case.
  - Staff from the State medical examiner's office.
  - An official from the Department of Education.

RAY FAMILY MEMBERS

At the time of Sabrina's death, the members of the Ray family included:

Misty Ray: Adoptive mother.

Marc Ray: Adoptive father.

See https://www.legis.iowa.gov/docs/publications/CI/1130515.pdf.

Sabrina Ray (16 years old), **XXXX Ray** (12 years old), **XXXX Ray** (10 years old); and **XXXX Ray** (10 years old): adopted children of Marc and Misty Ray.

Justin Ray: 21-year-old biological child of Misty Ray and adopted child of Marc Ray.

Josie Bousman: 20-year-old niece of Marc and Misty Ray.

Carla Bousman: Mother of Misty Ray.

EFFECT OF CONFIDENTIALITY ON THE REPORT

We spent a fair amount of time deliberating over what information should be included in the public version of this report. Although the Ombudsman is usually prohibited from re-disseminating confidential information acquired from an agency pursuant to an investigation, state law gives DHS authority to grant the release of such information when it relates to a child fatality. This explains why our report contains information that comes directly from child abuse and other DHS records involving the Ray family. We are only including, however, information that we believe is necessary to explain the problems we identified. At times, it was very difficult and heartbreaking to read what transpired in this case, but it is vital that the public and policy makers know what happened so steps can be taken to prevent similar tragedies.

We also needed to decide whether to name witnesses and government employees who were involved in the Ray case. Media reports had identified some of these individuals, including police officers and medical rescue personnel who responded to a 911 call from the Ray residence. Media reports also identified family members.

This report identifies some, but not all, of the current and former DHS employees we interviewed or who had contact with the Ray family. We chose not to name some employees if doing so would serve no public purpose.

Aside from DHS employees, we chose not to redact the name of the Mid-Iowa FSRP supervisor, or the former Mid-Iowa FSRP worker. We also created a pseudonym for a foster care family who was placed with the Rays in 2014.

Lastly, out of respect for Sabrina's younger siblings, we did not identify them by name.

Introduction

THE DEATH OF SABRINA RAY

> (Sabrina) was really sweet … (she) could have been something. … Sabrina was the main one who got beat the most. … Kids don't deserve that.
>
> *Former foster child placed in Ray home*[6]

> Just terror. That's all I feel. Being this close to it, you can feel it. It's in the air.
>
> *Neighbor of Ray family*[7]

> All three girls were very thin and their feet were a bluish/purple … due to them being on their bare feet all the time … overall, Marc and Misty and Justin treated the girls like animals.
>
> *Niece of Marc and Misty Ray*[8]

The call came in to the Perry Police dispatch center at around 6:24 PM, on May 12, 2017, about a 16-year-old girl who was not breathing. Officers Sienkiewicz and Rittman were dispatched and arrived at 1708 1st Street two minutes later. Officer Sienkiewicz retrieved the AED from the trunk of the patrol car while Officer Rittman went straight into the house. Officer Sienkiewicz entered the house soon after and was directed by a female to a room towards the back. He immediately stopped at the threshold.

"It was at this point that I saw the most horrific scene of my entire career and life. It is hard to put into words the feelings that came over me – the smells, the pain, the anguish, the fear, and the evil."

Officer Sienkiewicz felt an unknown force prevent him from entering the room. Based on his training and experience, he knew this was more than just a call about an unresponsive female. It was a crime scene.

The officers found Sabrina Ray lying on a mattress wearing only a diaper and a white tank top, her eyes and mouth still open and she was so skinny that her bones were apparent. She was covered in bruises and abrasions. It was clear that she was deceased. Four females stood around the doorway with the officers, emotionless: Sabrina's 10- and 12-year-old sisters, her grandmother, and her adult cousin. "They had no emotion . . . . There were no tears. There were no screams of sadness."

Officer Sienkiewicz became immediately fearful for the two girls, wanting to get them away from the room and keep them safe, however he could.

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[6] Laura Terrell, *Teen who lived with Sabrina Ray details horrific abuse,* KCCI, May 16, 2017.
[7] Tommie Clark, *Community remembers 16-year-old Sabrina Ray one year later,* KCCI, May 12, 2018.
[8] Perry Police Report, Incident Narrative 17-003267.

The Dallas County EMS soon arrived at the scene to Officer Sienkiewicz's relief. When the paramedics looked in the room, an expression of horrific disbelief came over one, and the words "Jesus Christ" were uttered by the other.

During the scene investigation, Officer Sienkiewicz saw a "baby monitor-like camera" in the room, a "magnetic type alarm" installed on the bedroom door, and observed that the bedroom window was covered. He also observed that the bedroom door had "some type of lock … at some point and then removed." Scene photographs reveal that screws were placed to keep the windows from opening, and holes on the bedroom door for a padlock. There were also locks and alarms on food and beverage pantries in the kitchen and family room.

The officers and a DHS field worker interviewed the two younger girls about what happened to their sister, but they were guarded in their answers. The sisters blamed themselves and Sabrina for bruises on their bodies, and they claimed no one would ever go without a meal. Officer Sienkiewicz recognized a pattern of deflection throughout the interview, and was very troubled by one of the girls' declaration: "They don't harm [Sabrina] in any way."

Officer Sienkiewicz observed the younger girl's body language and pauses in her answers that signaled to him she was rehearsing in her mind what she had been instructed to say. "Even though [she] was answering questions I knew she was concealing pain, fear, and anxiety."

Throughout the night, however, the girls became more comfortable and began to slowly open up. Of one of the sisters, Officer Sienkiewicz wrote, "I truly believe this was the first time in her life she saw a way out of this evil place."

Officer Sienkiewicz then felt the evil he had sensed when he first saw Sabrina. The girls revealed that they were instructed by their grandma not to say anything about the lock and the camera, and "not to say anything about the beatings." The girls opened up further and described how a couple of weeks earlier their brother had "kicked Sabrina down the stairs, bashed her head, stomped on her head, and broke her thumb." They described how they would get hit in the stomach with a hammer. On a shelf outside the girls' room, Officer Sienkiewicz located a hammer.

"[The girls] had seen the Department of Human Services come and go but they were still trapped in a hell that no one could begin to fathom or comprehend," Officer Sienkiewicz observed. "[They] were under an evil powerful control by their own parents that they couldn't reach out for help even though it was right in front of them."

"[The girls] had seen the Department of Human Services come and go but they were still trapped in a hell that no one could begin to fathom or comprehend."

The girls also revealed that their parents had threatened them if they told the truth. "They told us to lie to you guys," said one of the girls. "Our parents make us lie and say we are not abused, and tell us after you leave they will cause us more pain," said the other.

As the officers and DHS prepared to remove the girls from the home, Officer Sienkiewicz heard the most horrible statement made that night. As he touched one of the girls on her back to get her attention, the girl's entire body flinched. "I just get scared when people touch me because I

think they are going to hurt me, that's why I flinched."

While police, paramedics, and DHS processed the scene, Sabrina's adoptive parents, Marc and Misty Ray, were on their way to Disney World with her adopted brothers.[9]

Sabrina's cause of death was later determined by medical examiners to be severe malnutrition due to denial of critical care.[10] The 16-year-old was 4 feet, 7 ½ inches tall and weighed just 56 pounds.[11] The autopsy revealed that, based on the size and condition of her internal organs, Sabrina was likely subject to starvation over a long period of time.[12]

Following a police investigation, several members of Sabrina's family were criminally charged. They subsequently received prison sentences for their involvement with the maltreatment of Sabrina and her siblings. Misty pleaded guilty to one count of kidnapping in the first degree and two counts of kidnapping in the third degree and was sentenced to life in prison plus 20 years. Marc pleaded guilty to three counts of kidnapping in the third degree and one count of child endangerment resulting in death and received an 80-year sentence.

Carla Bousman pleaded guilty to one count of neglect of a dependent person, two counts of false imprisonment, one count of accessory after the fact, one count of obstruction of prosecution, and two counts of child endangerment. She received a 20-year sentence. Josie Bousman pleaded guilty to one count of neglect or abandonment of a dependent person and two counts of child endangerment and was sentenced to 14 years. Justin Ray pleaded guilty to two counts of willful injury causing bodily injury and received a 10-year sentence.

Officer Sienkiewicz recounted in his report his thoughts when Sabrina's sisters left the house, after he had spoken with them for five hours. "I remember thinking to myself that [the girls] were now going to be free and once they walked out that door a whole new world was waiting for them and I vowed to make sure they would be okay."

DHS'S CONFIDENTIAL BRIEFING

As Officer Sienkiewicz alluded to in his report, DHS was intimately familiar with the Ray family. At the time of Sabrina's death, DHS was involved with them through licensing the home as a Category C child-development home (in-home daycare). The Rays were previously an approved and licensed foster care home and also had been the subject of 11 child abuse reports.

In response to our request for the agency's internal investigation regarding its handling of child abuse reports, foster care licensing, and daycare licensing, DHS informed our office that a

[9] Lee Rood, *The short, troubled life of Sabrina Ray*, Des Moines Register, May 23, 2017.
[10] Kelly Maricle, *Medical Examiner: Sabrina Ray Died of "Malnutrition Due to Denial of Care,"* WHO, August 16, 2017.
[11] Sabrina actually weighed less than she had five years prior, when she was adopted by the Rays. Sabrina was adopted by the Rays on January 31, 2012, at age 11, and at that time, she weighed 57 pounds. Six months later, she weighed 53.8 pounds, according to the DHS's Confidential Briefing. Additionally, according to the police report, Marc and Misty's niece reported to law enforcement that "Sabrina used to be taller than her (the niece) and now she only came up to her shoulder."
[12] Telephone call with Dr. Jonathan Thompson with the Iowa Office of the State Medical Examiner on March 2, 2020.

"Confidential Briefing" summary was created in 2017 for Iowa legislators. No other internal investigatory document exists.[13]

OMBUDSMAN INVESTIGATION

We first heard of Sabrina Ray through media reports a few days after her death on May 16, 2017. We issued a notice of investigation to DHS on May 25, 2017, and requested all child abuse intakes and assessments involving the Ray family, as well as copies of all records related to child abuse and/or licensing suspensions or revocations involving the Rays' daycare.

The Ray investigation was the third child death case that we undertook within an eight-month span. It should be noted, however, that there are other government bodies with oversight responsibilities that had the authority to review the circumstances surrounding Sabrina's death and DHS's actions in the case: the Child Fatality Review Committee, Child Death Review Team, multidisciplinary teams, and child protection services citizen review panels. We examined these entities and their capability of handling an in-depth child death investigation in our investigation into the death of Natalie Finn.

THE HIRING OF AN OUTSIDE REVIEWER

Following Sabrina's death, a DHS official acknowledged that the Ray case had some similarities to the Finn case. On May 16, 2017, DHS announced its decision to hire an outside expert to review DHS performance and make recommendations on how it could strengthen its practices and support its staff to keep children safe from abuse and neglect.[14] DHS officials reported on June 5, 2017, that they chose the Child Welfare Policy and Practice Group (CWG), a nonprofit providing child welfare assistance, to "look at all areas of system functioning and identify system challenges and potential solutions…. Essentially, they'll be looking for any system barriers so that we can target those areas for improvement."[15]

At that time, it was unclear whether the outside reviewer would examine the Finn and Ray cases. Shortly thereafter, we received clarification from a DHS official that CWG would not be reviewing DHS's handling of the Finn case or the Ray case.

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[13] This is distinct from DHS's response to the death of 16-year-old Natalie Finn, who died on October 25, 2016, while there was an open child abuse assessment. In that case, DHS conducted an internal review of the department's involvement with the family, which led to the release of an "Executive Summary," a document provided to our office detailing the specific findings and conclusions of the internal review.

[14] DHS's May 16, 2017, public statement read:

> We are coordinating with law enforcement in investigating the death of a 16-year-old girl from Perry. We want to convey our deep sadness at the loss of this young woman. We are taking a comprehensive review of our child welfare system and want to assure the public of our commitment to protecting vulnerable children.
>
> As a result, we are immediately beginning the process of engaging an outside expert to examine DHS performance, and make recommendations on how we can strengthen our practices and best support our staff as we work to keep children safe from abuse and neglect. We are in discussions with Casey Family Programs, a national child welfare organization, in identifying next steps in arranging for this outside expert.

[15] DHS's press release, *DHS Engages National Expert for Child Welfare Review*, June 5, 2017.

CWG subsequently issued a report on December 22, 2017, titled "Initial Targeted Child Welfare Review." CWG found that DHS officials had been forthcoming about addressing the agency's limited resources and the challenges of "doing more with less." This had, according to the report, a negative impact on staff morale and system performance. Regardless, the reviewers believed DHS had a "foundation of assets" that could sustain it, including hope in new agency leadership (the hiring of Jerry Foxhoven in 2017),[16] a seasoned and dedicated workforce, and committed community partners and families.

[16] Foxhoven was described at the time as "a well-known and highly respected leader in child protection and family law," according to a June 2017 press release by the office of Governor Kim Reynolds. Foxhoven's employment as DHS director ended two years later on June 17, 2019.

Marc and Misty Rays' daycare license and foster care license

RAYS' DAYCARE LICENSE

At the time of Sabrina's death, Marc and Misty were operating a licensed daycare out of their home named "Rays of Sunshine." The type of daycare they operated was referred to as a "child development home," which DHS separates into categories A, B, and C. Certain regulations must be followed in order to maintain a daycare license.[17]

Assuming DHS's practices and procedures were followed, the Rays underwent a pre-inspection process when they started their child-development home. DHS would have visited the home and gathered certain documentation to show the qualifications and fitness of the provider and home.[18] The three categories of child-development homes require an annual, unannounced compliance visit, and all homes must complete the registration process every 24 months.[19] If areas of the Ray's home were determined to be out of compliance with DHS standards, the agency may have allowed them a period of time to correct the issues.[20] Depending on the area of noncompliance, a second visit to their home may have been required to ensure full compliance. Otherwise, DHS's employee manual would have allowed the Rays to self-certify that the issues had been corrected.[21]

We learned that DHS approved Misty as a Category A daycare provider on May 1, 2004. This allowed her to care for up to eight children (six pre-school age and two school age). Through the years, the Rays continued to operate the daycare, expanding to a Category B child-development home, and then a Category C, with Marc and Misty listed as the two required daycare providers for up to 12 children.

Throughout the 13 years the Rays operated a licensed child-development home, DHS conducted inspections of the daycare, as well as reviews every two years of the Rays' re-registration.[22] On a number of occasions, DHS determined that the daycare was out of compliance in certain areas, though no action was taken against the Rays' license.

DHS's unannounced home compliance visit on December 1, 2016, was its last at the Ray home prior to Sabrina's death five months later.

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[17] Child-development homes with five or fewer children in the home are not required to maintain a daycare license through DHS. These homes are considered "unregistered." IOWA CODE § 237A.

[18] IOWA ADMIN. CODE r. 441—110. Prior to registration, the provider must complete minimum health and safety trainings, as well as mandatory reporter trainings and first aid and CPR training. During the registration process, DHS must conduct criminal history and records checks. DHS also conducts records checks on any other person in the home who is 18 years of age or older.

[19] IOWA ADMIN. CODE r. 441—110.3 and 110.4

[20] DHS's Employees' Manual, Title 12, Chapter F, Page 52.

[21] *Id.*

[22] According to records available, DHS conducted compliance visits to the Rays' child-development home each year for the 13 years the daycare was in operation, with the exception of 2005, 2008, 2009, and 2012.

RAYS' FOSTER CARE LICENSE

In addition to obtaining a daycare license, the Rays also received a foster care license through DHS.

DHS first issued Marc and Misty a foster care license on March 1, 2006. To be approved, the Rays had to pass records checks, a home study, and face-to-face interviews.[23] DHS contracts with private agencies to complete the home studies and review potential foster homes, and to make recommendations to DHS; however, DHS retains final decision-making authority whether to issue a license.[24]

The Rays, as with all foster parent applicants, would have completed specialized training, including mandatory reporter and cardiopulmonary resuscitation (CPR) training.[25] A license is valid for one year from the date of issuance and must be renewed annually. The Ray's license was renewed every year until they chose to not renew. Their foster care license was officially "closed" January 28, 2016.

According to DHS records, the Rays had a total of 23 foster care placements between 2006 and 2014, which resulted in four adoptions, including Sabrina.[26] Sabrina was placed in foster care at the Rays on April 1, 2011. Marc and Misty adopted her 10 months later on January 31, 2012. The last children placed in foster care with the Rays left the home on July 28, 2014.

Certain conditions require DHS to revoke a foster care license, including when any person residing in the foster family home has been convicted of a crime or has a record of founded child abuse reports, when the foster parents are "operating without due regard for the health, sanitation, hygiene, comfort, or well-being of the children in foster care," or if the foster parents are misusing DHS-furnished funds.[27] DHS may also revoke a foster care license when the family:

- ♦ Fails to continue to comply with all the licensing requirements in law and regulation;
- ♦ Fails to meet one or more requirements in the placement agreement;
- ♦ Fails to notify the licensing worker of a move to another home within seven working days after the date of the move; or
- ♦ Refuses to cooperate with an unannounced visit.[28]

[23] IOWA ADMIN. CODE r. 441—113.
[24] DHS's Employees' Manual, Title 12, Chapter B, Page 79.
[25] IOWA ADMIN. CODE r. 441—113.
[26] DHS's Confidential Briefing.
[27] DHS's Employees' Manual, Title 12, Chapter B, Page 122. For criminal convictions and founded child abuse reports, DHS has the discretion to determine whether the conviction or founded report merits prohibition of the licensure.
[28] DHS's Employees' Manual, Title 12, Chapter B, Page 123.

DHS may make the decision to suspend, rather than revoke, the family's foster care license, and do so either as an emergency or time-limited suspension.

Suspensions may occur if the licensee fails to meet the licensing requirements and the health safety, and welfare of a child placed in the home requires immediate action. A license may undergo a "time-limited suspension" if the condition creating the health, safety, and welfare threat can be corrected by the foster parent. In those cases, the parent must sign a written statement that acknowledges the existence of the threat identified and commits to correct the condition.[29]

Between March 2006 and July 2014, Iowa Kids Net[30] support workers conducted a total of 19 visits to the Rays' home. The support workers also conducted two visits prior to the issuance of the foster care license in 2006.[31] According to DHS's Confidential Briefing, no concerns were noted during Iowa Kids Net support workers' visits to the home, and the Rays were recommended for license renewal every year.

While the Rays' license was never suspended or revoked, it was once placed on "hold" on April 10, 2014, following receipt of a child abuse report that same day concerning physical abuse and "denial of critical care" allegations. The hold did not formally suspend or terminate the Rays' license, but meant that they would not receive any future foster care placements. Despite the hold, DHS kept three foster care children in the home.

[29] IOWA ADMIN. CODE r. 441—112.
[30] *Id*. Iowa Kids Net was a contracted agency that completed home studies and reviews of foster homes at that time; DHS now contracts with Four Oaks Foster & Adoptive Family Connections for these services.
[31] *Id*.

DHS's Intake and Assessment Process and the Five Child Abuse Reports Received Between 2010-2013

DHS'S INTAKE PROCESS

Iowa law designates DHS as the agency responsible for receiving and investigating reports of child abuse and ensuring that children are safe.

DHS is required to maintain a toll-free telephone line, available on a 24/7 basis.[32] Most child abuse reports are received through calls to the toll-free Child Abuse Hotline operated by DHS.[33] When DHS receives a child abuse report, staff conducts an intake to determine if the report should be accepted or rejected. DHS has previously acknowledged:

> Intake decisions are critical, because they represent the "front door" to the child welfare system. Balancing of the need for the department to protect a child from abuse against the possibility of unnecessary intrusion into a family is a delicate one, but one that should always tilt toward protection of the child.[34]

The Centralized Services Intake Unit (CSIU) accepts child abuse reports Monday through Friday, 8:00 a.m. to 4:30 p.m.[35] Although CSIU is open for only 42½ hours in a typical week, or roughly one quarter of the hours in a week, the unit on average handles three out of every four child abuse reports.[36] Calls outside of those hours, including calls on weekends and holidays, are handled through an after-hours on-call system.

CSIU receives an average of 250 calls per day.[37] Around 180 of those calls are intakes for child abuse, Child in Need of Assistance (CINA), and Dependent Adult Abuse (DAA).[38] When a person calls the hotline, an automated system offers recorded information and several options. The caller's choices help route the call to appropriate staff in the shortest time possible. There is never a busy signal, and calls are held within the system until answered or abandoned by the reporter.[39]

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[32] IOWA CODE § 235A.14(3).

[33] Child abuse reports can also be received by local DHS offices and the central abuse registry, but DHS said it is "a rare occurrence."

[34] DHS's Executive Summary of the death of Natalie Finn, Page 2.

[35] DHS's response to our Finn report stated: "The Department is also exploring approaches to develop a 24/7 call center in partnership with multiple state agencies. We are currently working through the details of what this comprehensive approach may include."

[36] DHS, *Centralized SA CY 2018-2019 Unit Strategic Plan*.

[37] *Id.* According to CSIU's *Operational Manual*, in addition to child abuse intakes, CSIU also receives several other types of calls:

- Child in need of assistance (CINA) intakes: These calls involve requests for juvenile court adjudication concerning a child alleged to be a CINA.
- Dependent adult abuse (DAA) intakes: These calls involve reports alleging that a dependent adult has suffered abuse or neglect by a caretaker or through self-denial as defined by Iowa law.
- Information and Referral (I&R): These involve calls which are not processed as a child abuse intake, DAA intake, or CINA intake.

[38] *Id.*

[39] CSIU's *Operational Manual*, Page 10.

According to DHS, all phone lines answered by CSIU intake workers are recorded and stored electronically.[40] Management and information-technology staff have access to the recordings, which are retained for three years. Two Social Worker 4s listen randomly to one call each month for every intake worker "as a part of quality assurance activities."[41]

Calls to the Child Abuse Hotline outside normal CSIU business hours are answered by staff at the State Training School (STS) in Eldora.[42] The STS workers who handle calls to the Hotline are not trained as intake workers; they function more like an answering service. After a call is received, the STS worker contacts a field worker who is on call in the county where the child resides. The STS worker relays the information to the field worker, who then calls the reporter to conduct an intake.

DHS accepts a child abuse report for assessment when three criteria are met:

1. The alleged victim is a child, defined as any person under 18;[43]

2. The alleged perpetrator is a caretaker,[44] defined as a person responsible for the care of the child;[45] and

3. The alleged incident falls within the statutory definition of child abuse.[46]

Every new intake is assigned a timeframe for a supervisor to accept or reject the child abuse report. There are only two options: one hour (where there is high risk of injury or an immediate threat to safety); or 12 hours (where there is no high risk of injury and no immediate threat to the child).

DHS's Assessment Process

The preamble to DHS's child-welfare administrative rules reads: "The assessment-based approach recognizes that child protection and strong families are the responsibility not only of the family itself, but also of the larger community (including formal and informal service networks)."[47]

When intake staff accepts a child abuse report for an assessment, the case is assigned to a field worker to evaluate the child's safety and the family's strengths and needs. The field worker then decides if steps need to be taken to ensure the child's safety and/or to involve the family in support services.

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[40] DHS's November 2, 2017, letter of response to our inquiry made in the Finn investigation.
[41] *Id.*
[42] The STS is a residential facility for male juvenile offenders that is managed by DHS.
[43] Iowa Code § 232.68(1).
[44] Iowa Admin. Code r. 441—175.21.
[45] Iowa Admin. Code r. 441—175.24(1)(b). An alleged perpetrator can also include a person who resides in a home with the child, if the allegation is sexual abuse as defined in Iowa Code section 232.68(2)(a)(3) as amended by 2016 Iowa Acts, Senate File 2258; or a person who engages in or allows child sex trafficking as defined in Iowa Code section 232.68(2)(a)(11) as amended by 2016 Iowa Acts, Senate File 2258.
[46] Iowa Admin. Code r. 441—175.24(1).
[47] Iowa Admin. Code r. 441—175 (Division II, Preamble).

There are two types of assessments: a child abuse assessment and a family assessment.[48] The family assessment is for "less serious allegations of child neglect."[49] It is only used in "denial of critical care" cases where the child is not in imminent danger.[50] The family assessment is not used in physical or sexual abuse cases, or other types of serious abuse cases. The intent of the family assessment is to match families with services and supports, such as counseling or public assistance.[51] A field worker must begin a family assessment within 72 hours of receiving the report. The case is reassigned to a child abuse assessment any time it appears the child is not safe.

An accepted intake will lead to a child abuse assessment when it involves any non-accidental physical injury, or an injury that does not match the history given for it, that is suffered by a child as a result of the acts or omissions of a person responsible for the care of the child.[52] In addition, any allegation involving "denial of critical care" that alleges imminent danger, injury, or death to a child will result in a child abuse assessment.[53] A field worker must begin a child abuse assessment within 24 hours of receiving the report.

All assessments are required by law to address child safety, family functioning, culturally competent practice, and family strengths and needs.[54] The primary purpose of any assessment is to protect the child named in the report, while the secondary purpose is to engage the child's family in support services, if necessary, to address any needs identified by the field worker.[55] The information gathered during an assessment is documented in either a "Child Protective Services Family Assessment Summary" or a "Child Protective Services Child Abuse Assessment Summary" form.

Field workers are advised that an incremental response is possible during the assessment process; the appropriate path for each case depends on the unique characteristics of each family and situation.[56] If a field worker has concerns about a child's safety or a family's functioning, the worker is required to conduct a more intensive assessment until those concerns are addressed.[57]

With the consent of the parent or guardian, a field worker may visit the home of a child named in a report to interview or observe the child.[58] The alleged victim's siblings and any other children under the care of the alleged perpetrator must be interviewed to ensure their safety and to

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[48] IOWA CODE § 232.68(5).
[49] From a May 1, 2015, presentation, titled "Differential Response," by Julie Allison, then-Bureau Chief for DHS's Bureau of Child Welfare and Community Services.
[50] See "Iowa Child Welfare Assessments by Disposition, County and Year" at https://data.iowa.gov/Public-Safety/Iowa-Child-Welfare-Assessments-by-Disposition-Coun/er5e-kmgq.
[51] *Id*.
[52] IOWA CODE § 232.71B(1)(a)(1).
[53] *Id*.
[54] IOWA CODE § 232.68(5)(a).
[55] IOWA CODE § 232.71B(1)(b).
[56] DHS's Employees' Manual, Title 17, Chapter B(3), Page 3.
[57] IOWA ADMIN. CODE r. 441—175.25(5)(a)(2).
[58] IOWA CODE § 232.71B(6).

determine whether they witnessed the alleged abuse.[59] All assessments must include a safety assessment[60] and a risk assessment,[61] as well as an evaluation of the home environment.[62]

Field workers are trained to observe the child's environment to gather evidence and determine whether it poses a safety risk, such as drug use and adequacy of food.[63] If permission to enter the home is refused, the juvenile court or district court may, upon a showing of probable cause, authorize the field worker to enter the home and interview or observe the child.[64]

A child abuse assessment requires a determination of whether abuse occurred, and if so, a determination of whether the incident should be placed on the central abuse registry.[65] The determination of whether abuse occurred is based on a "preponderance of evidence" standard.[66] In contrast, a family assessment does not include a determination of whether abuse occurred.[67]

2010 Child Abuse Intakes and Assessments

DHS responded to our May 25, 2017, request for child abuse intakes and assessments by providing us with 10 of the 11 child abuse reports that were filed on the Ray family. The first child abuse report was dated October 15, 2010, and the last was dated November 2, 2015.

Three child abuse reports filed in four months

DHS received a child abuse report from a school employee on October 15, 2010, concerning a 5-year-old foster care child living with the Rays. According to the intake document, the reporter alleged that Marc and Misty locked the child in a closet as a form of punishment when she defecated in her pants. The reporter indicated that the information came from the victim's sibling, who also lived with the Rays.

The intake was accepted for a child abuse assessment. According to the child protective assessment summary, the foster care child told the field worker in an interview at school that when she gets in trouble she has to go to "time out" on the couch. The field worker also interviewed the child's sibling, who reported the issue to school staff. The sibling indicated that "they play lock" and get spanked when she gets in trouble at the Rays.

The assessment summary indicates that the field worker made multiple unannounced visits to the

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[59] DHS, *How-Do-I? Guide CPS Assessment,* Page 5. The Title 17 Appendix describes the document as "a desk aid for departmental staff regarding general procedural steps during a CPS assessment."
[60] A safety assessment identifies and addresses imminent threats to a child's safety, according to DHS's November 2, 2017, letter of response to our inquiry made in the Finn investigation.
[61] DHS's November 2, 2017, letter of response to our inquiry made in the Finn investigation, stated that a risk assessment is a predictor for a child's future risk to abuse. According to Page 8 of DHS's *How-Do-I? Guide CPS Assessment*, "A risk assessment … looks at the likelihood of future abuse. Risk level is used to make decisions about the provision of services to the family based upon the family's strengths, needs, and prior history."
[62] Iowa Code § 232.71B(4)(a)(2).
[63] DHS, *How-Do-I? Guide CPS Assessment,* Page 5.
[64] Iowa Code § 232.71B(6).
[65] Iowa Code § 232.68(5)(b). In completing a child abuse assessment, field workers must make an allegation finding of either founded, confirmed, not placed on registry, or not confirmed.
[66] DHS's Employees' Manual, Title 17, Chapter B(1), Page 37.
[67] Iowa Code § 232.68(5)(c).

home and observed the closets in the home. One bedroom was found to have a lock on the outside of the door, but it was not functioning. Another bedroom, the one belonging to the foster care child and other girls, had an alarm on the door, which Marc explained was for purposes of letting them know when the children were up at night, and was not a lock. Marc denied locking the child in a closet.

The assessment summary concluded that it could not be determined the Rays were using the kind of discipline alleged.

While reviewing this intake report, we discovered a child abuse report that had not been provided to our office. The report was filed on August 20, 2010, two months prior to the first report we received. DHS records suggest that this intake was accepted, and an assessment had been completed on September 21, 2010. Marc and Misty were the alleged perpetrators and one of their adopted daughters was identified as the alleged victim. At that time, the child would have been 5 years old.

Asked why we had not received records associated with the August 20, 2010, child abuse report, DHS said that all records connected with this intake and assessment were expunged on August 22, 2015, in accordance with the department's 5-year record-retention schedule.[68] As a result, no other information is available about either the intake or the assessment, including who the reporter was, the type of abuse alleged, and the outcome of the assessment.

Asked why we had not received all of the records, DHS said they had been destroyed pursuant to its 5-year retention schedule.

It is notable that the October 2010 report, and another report received in November 2010, were both retained by DHS despite its record retention policy. If DHS policy had been followed, both subsequent reports and assessments should have been expunged shortly after the August 20, 2010, intake and assessment records were expunged.

Despite the October report having been "not confirmed," the DHS field worker who handled the assessment made a separate child abuse report on November 2, 2010, to DHS with concerns about the Rays' ability to meet the foster care child's mental-health needs. According to the intake document, the field worker reported that the child had several severe behaviors and had missed several therapy sessions.

The intake was accepted for a child abuse assessment and assigned to the same field worker who made the report and handled the previous assessment. According to the assessment summary, the field worker spoke with the child's mental-health services provider and learned that she had not received any individual counseling, despite the Rays' attempts to get counseling for her worsening behavior.

The field worker determined that services were needed for the child. However, Marc and Misty reported to the field worker that they could no longer handle her behaviors, and it was decided

[68] IOWA ADMIN. CODE r. 441—175.32.

that the child would be placed in a different living arrangement. The finding of the child abuse assessment was not confirmed.

We received information that, as the result of the child abuse reports received in 2010, the Western Service Area – which covered Carroll – had concerns about the family and determined that a corrective action plan was needed to address issues relating to training. But shortly after these reports were made, the family moved to Perry, Iowa, which is part of the Des Moines Services Area.[69] The responsibility of implementing a corrective action plan was transferred to the Des Moines Service Area.

It does not appear, however, that this ever occurred.[70]

After the Rays' move back to Perry, Sabrina was placed in foster care on April 1, 2011, and formally adopted by the family on January 31, 2012.

Abuse allegations not shared with daycare licensing

DHS's Employees' Manual states that "When it is alleged that child abuse has occurred in a child-development home, the protective service worker will immediately inform the child care registration worker."[71] The daycare licensing worker's role in an assessment of alleged abuse is to "focus on compliance issues with the child care law and the requirements for registration." When a daycare licensing worker is notified of child abuse allegations, it is considered a complaint against the daycare.[72] DHS may deny, suspend, or revoke a registration if it has been shown that the provider(s) are not operating the daycare in compliance with Iowa law or rules, or if DHS finds a hazard to the safety and well-being of a child that is not corrected by the provider.[73]

We found no indication that the daycare licensing worker was informed about the allegations raised in any of the child abuse reports received about the Rays in 2010.

We found no indication that the daycare licensing worker was informed about the allegations raised in any of the child abuse reports received about the Rays in 2010.

SEPTEMBER 13, 2013 REJECTED INTAKE

Shelby Messersmith was a Family Safety, Risk and Permanency (FSRP) worker assigned to a 16-year-old child who was placed in foster care with the Rays in 2013. FSRP workers contract with DHS to "promote safety, permanency, and well-being for children" under DHS's supervision. These services include interventions to preserve families, managing family reunifications, and making

[69] It is our understanding that the Rays moved to Carroll in August 2009, after previously residing in Perry. The family subsequently moved back to Perry in January 2011. See also Iowa Department of Human Services Service Area Map 2017 (https://bidopportunities.iowa.gov/Home/GetBidOpportunityDocument/9c273f34-d6c0-47d4-9e31-66081cbde478).
[70] Telephone call with a DHS prevention program manager on March 2, 2020. She shared that she believes that the failure of the Des Moines Service Area to implement a corrective action plan was a "missed opportunity."
[71] DHS's Employees' Manual, Title 12, Chapter F, Page 64.
[72] *Id.*
[73] IOWA CODE § 237A.

adoptive or guardianship placements for children who cannot return home.[74] The company Messersmith worked for was Mid-Iowa Family Therapy Clinic (Mid-Iowa).

Messersmith made a child abuse report to DHS on September 13, 2013, alleging that Misty was not re-filling the foster care child's Ritalin prescription. The child told Messersmith that he had been without his medication for two months and had been struggling in school. Additionally, Messersmith reported that Marc and Misty called him a "fat ass" and showed him pictures of his parents on what was referred to as "meth Facebook pages."

The intake worker discussed the allegations with her supervisor, Mike Allison, who made the determination that the report would be rejected. The rejection explanation provided on the intake document stated "insufficient reason to suspect child denied adequate care." The concerns were then referred to the assigned DHS ongoing-services worker to be addressed with the Rays which, according to DHS's Confidential Briefing, occurred during a family team meeting.

In addition to the report made by Messersmith, DHS's ongoing-services worker for the child contacted the foster care licensing worker regarding concerns that Misty had called the child and other children in the home inappropriate names. Although the ongoing-services worker did not believe that the treatment amounted to abuse, she wanted to make the foster care licensing worker aware of what was happening in the home.

We found no indication that daycare licensing staff were informed about the child abuse report, as required by DHS policy.

We found no indication that day-care licensing staff were informed about the child abuse report, as required by DHS policy.

SEPTEMBER 20, 2013 ACCEPTED INTAKE AND ASSESSMENT (NOT CONFIRMED)

DHS received another child abuse report from Messersmith on September 20, 2013 – this time concerning three adopted children in the Ray home. According to the intake document, Messersmith alleged that Marc and Misty physically abused Sabrina and her sisters. Specifically, she claimed that the children were "beat in the basement" and that Misty had "slapped [Sabrina's sister] off of a chair" when the child had not completed her homework.

Messersmith also reported that Marc and Misty withheld food from all three girls as a form of discipline.

The intake was accepted for a child abuse assessment. According to the child protective assessment summary, the field worker made an unannounced visit to the Ray home and learned that the Rays admitted to using physical punishment on their children. The Rays described the degree of the contact as an open-handed swat on the bottom or a swat near their mouth. Misty reported that the majority of the time ("85%"), they use time outs as punishment. Marc and Misty denied spanking their children in the basement.

[74] https://www.miftc.com/services/

Marc and Misty also denied taking away the children's food as punishment, but claimed that they had to monitor the children's food because "[Sabrina's sisters] are obsessed with food" and would hide food even after they just ate a meal.

The field worker spoke to Sabrina and her minor siblings alone. Sabrina and her sisters reported that they do not get spanked, and instead go to time out or their room when they get in trouble. Sabrina's minor adopted brother reported to the worker that Misty spanked Sabrina with a belt, but Sabrina stated that was not true. The children also reported that they had plenty of food to eat in the home and did not get food taken away as punishment.

No referral was made to DHS daycare licensing staff about the child abuse report.

SEPTEMBER 22, 2013 DAYCARE LICENSING COMPLAINT

During the course of this assessment, a separate complaint was made directly to DHS daycare licensing on September 22, 2013, by an employee from Mid-Iowa, the company that provided FSRP services to DHS. The employee was also a mother, whose child previously attended the Rays' daycare. She reported that Marc and Misty were providing improper meals and were engaging in improper discipline and supervision. She further explained that the Rays had inappropriate conversations around the children and called the children degrading nicknames. This was the third person to claim that the Rays were calling children inappropriate names.[75]

The Mid-Iowa employee also stated that Sabrina had become "extremely thin and withdrawn" and was "starved for social interaction."

Daycare licensing staff initiated an investigation, and two workers visited the Ray home on October 2, 2013. DHS documents indicate that "neither DHS worker was able to observe or find any evidence from complaint allegations."

The DHS field worker handling the open child abuse assessment spoke with the daycare licensing staff about the concerns as well. The assessment was completed on October 18, 2013. The field worker determined there was insufficient information to show that physical abuse had occurred or that Marc and Misty were withholding food from the adopted children. She found that the "children were observed to be thin but not abnormally thin," and the children reported that they had plenty of food to eat. The allegations were not confirmed.

Though it appears that the daycare licensing staff completed an investigation, it was the result of a complaint made directly to that unit. It was not based on a referral from the child abuse intake unit.

[75] Following Sabrina's death, Carla Bousman referred to one of Sabrina's sisters as "our little midget" to first responders and law enforcement. According to DHS's Confidential Briefing, the 10-year-old weighed only 21 pounds at the time of Sabrina's death and had previously seen a medical provider at the University of Iowa Hospitals and Clinics in March and October 2013 for "small stature, poor growth, chromosome disorder." A law enforcement officer wrote in the police report that the comment was "not only demeaning and cruel but also not appropriate in any way for a human being let along a young girl."

ANALYSIS

We are unable to make any findings regarding the August 20, 2010, accepted intake and assessment because any records of the case were destroyed pursuant to DHS's record retention policy.

Accepted intakes are retained based on the finding of the assessment. "Confirmed" and "not confirmed" child abuse assessments are to be kept for five years, or five years from the date of closure of the service record, whichever occurs later.[76] Assessment summaries of "founded" child abuse reports are kept on the Child Abuse Registry for 10 years (or 10 years after the most recent confirmed abuse when the same victim or person responsible is placed on the Registry).[77]

It is unfortunate that records from the August 20 intake and assessment were unavailable to us, as this was the first of three accepted intakes received within a three-month period in 2010. Additionally, we are unaware why or how the August 2010 intake and assessment were unavailable, while the October and November 2010 intakes and assessments were available.

Based on our review of the October 15 and November 2, 2010, intakes and assessments, we do not have any major concerns with how these were handled. It is worth noting, however, that the allegation in the October accepted intake led to the field worker discovering bedroom doors were fitted with an alarm system. Seven years later, medical personnel responding to the emergency call about Sabrina's death noted that there was a "magnetic type alarm" installed on the bedroom door.[78]

What is most concerning is the information we received about the failure of DHS's Des Moines Service Area to implement a corrective action plan with the Rays following their move back to Perry. Although there are limited details regarding the corrective action plan that was envisioned by the Western Service Area while the Rays were in Carroll, it is apparent that DHS determined review and oversight with the family was necessary. Because nothing was implemented, the Rays maintained their foster care status and later adopted Sabrina.

Regarding the rejected intake from September 13, 2013, we do not, for the most part, have concerns with the manner in which this was handled. It was appropriately referred to the ongoing-services worker, and concerns were raised at the family team meeting. This was, however, the first instance in which it had been reported that the Rays were using inappropriate name-calling and nicknames for the children in the home. The issue arose again in a complaint made to daycare licensing around this same time by both the DHS ongoing-services worker for the foster child as well as a Mid-Iowa employee. Although the name-calling may not have met the definition of child abuse, it is an important indicator as to how the Rays diminished and treated children in their home.

Although name-calling may not met have the definition of child abuse, it is an important indicator as to how the Rays diminished and treated children in their home.

[76] IOWA ADMIN. CODE r. 441—175.32(3)(b) and 175.32(4)(b).
[77] DHS, *Notice of Child Abuse Assessment: Founded*, 470-3243 (Rev. 3/17)
[78] Mandatory Reporter form submitted by Dallas County EMS paramedic, May 15, 2017.

We also found that the September 20, 2013, intake and assessment were, for the most part, appropriately handled. However, it is notable that the assessment's conclusion twice mentions the appearance of the children, and specifically Sabrina. The field worker documented that the children appeared thin "but not abnormally thin," and the Mid-Iowa employee who submitted a complaint to daycare licensing during that same time period stated that Sabrina was "extremely thin." The September 20 accepted intake was the first of four food-related child abuse reports that would be filed against Marc and Misty until the time of Sabrina's death.

One criticism we do have for all the child abuse reports received during this timeframe (for which we received records) is the repeated failure to share information about the allegations of child abuse with DHS daycare licensing staff.[79] Though daycare licensing did complete an investigation into a complaint received from a Mid-Iowa employee, it was not the result of the child abuse report received around the same time period.

CONCLUSIONS AND RECOMMENDATIONS

The DHS Employees' Manual indicates that "[w]hen it is alleged that child abuse has occurred in a child-development home, the protective service worker will immediately inform the child care registration worker."[80] The daycare licensing worker's role in an assessment of alleged abuse is to "focus on compliance issues with the child care law and the requirements for registration." When a daycare licensing worker is notified of child abuse allegations, it is considered a complaint against the daycare.[81] We found no indication that daycare licensing staff were informed about the allegations raised in any of the child abuse reports filed in 2010 and 2013.

This investigation, as well as our investigation into the death of Natalie Finn, has brought to light the problem created by DHS's limited record-retention policy. Because records from the August 2010 intake and assessment were not available, we were unable to assess whether that report included any food-related allegations, as later reports would. The September 20, 2013, intake and assessment was the first instance in which food-related allegations were made against the Rays. This early case could have been an important tool for any intake or assessment worker to connect the dots when additional child abuse reports were made.

Older records are equally important to an outside reviewer such as the Ombudsman. The absence of records prevents us from reaching a firm conclusion on the appropriateness of DHS's responses to the August 2010 report. Additionally, the inconsistent retention of child abuse reports and assessments is significant.

In response to questions posed during our Finn investigation, Vern Armstrong, Administrator of DHS's Division of Field Operations, told us that maintaining everything in the digital age costs money and resources. It is not clear what the actual costs of maintaining these files would entail, and it is hard for us to believe digital storage costs for these files would be overly burdensome. Our position is that any potential cost is offset by the benefit of identifying patterns of child abuse and preventing potential tragedies as occurred in these cases. Record retention policies in

[79] DHS's Employees' Manual, Title 12, Chapter F, Page 64: "When it is alleged that child abuse has occurred in a child development home, the protective service worker will immediately inform the child care registration worker."
[80] DHS's Employees' Manual, Title 12, Chapter F, Page 64.
[81] *Id.*

several other states acknowledge that multiple reports involving the same subjects – regardless of whether the intake was rejected – justify longer retention of child abuse records.

A comparison of other states' record retention policies reveals a deficiency in DHS's policy. New Hampshire's Bureau of Child Protective Services (Bureau) retains rejected intakes for a minimum of four years. If the Bureau receives another report "concerning the same alleged perpetrator or the same child or any siblings or other children in the same household or in the care of the same adults during that timeframe," it "shall retain information from the prior and subsequent reports for an additional 4 years from the date a subsequent report is [rejected], an additional 10 years from the date a subsequent report is deemed unfounded, and indefinitely if the subsequent report is deemed founded or unfounded but with reasonable concern."[82]

For intakes that are accepted and trigger an assessment that confirms child abuse occurred, the Bureau retains those founded reports indefinitely, as well as reports that are "unfounded but with reasonable concern." Other unfounded reports are kept for 10 years, but if the Bureau receives another report about any of the same subjects during that timeframe, the retention period is extended another 10 years from the date the subsequent report is rejected or deemed unfounded. Unfounded reports can be kept indefinitely if a subsequent report is founded.

Indiana's Department of Child Services (DCS) retains audio recordings of child abuse hotline calls for 24 years from the date of the call. Unsubstantiated case files are kept for 24 years after the birth of the youngest child named in the assessment report as an alleged victim.[83] DCS retains substantiated case files indefinitely, unless expungement of the record is ordered by a court or administrative law judge.[84]

We believe that increasing record-retention timeframes by adopting laws similar to those in New Hampshire and Indiana would help DHS staff identify patterns of child abuse and help protect the safety and welfare of children in Iowa.

Identical to the recommendations in our investigation into the death of Natalie Finn, the Ombudsman recommends that DHS:

1. **Modify its administrative rules to increase the retention period for child abuse intakes and assessments as follows:**

    a. **At least five years for rejected child abuse intakes, and an additional five years if DHS receives another report concerning the same subjects or any siblings or other children in the same household or in the care of the same adults during that timeframe.**

    b. **At least 10 years for "confirmed" and "not confirmed" child abuse assessments, or 10 years from the date of closure of the case file, whichever**

[82] http://www.gencourt.state.nh.us/rsa/html/XII/169-C/169-C-35-a.htm.
[83] https://www.in.gov/dcs/files/2.13%20Expungement%20of%20Records.pdf.
[84] Indiana's policy appears to make no mention of rejected intakes, or how long the records of rejected intakes must be retained.

occurs later. In addition, if DHS receives another report concerning the same subjects or any siblings or other children in the same household or in the care of the same adults during that timeframe, DHS shall retain these abuse assessments for an additional 10 years.

c. Indefinitely for "founded" child abuse assessments.

2014 Events and Issues

Between April and November 2014, DHS received five child abuse reports about the Rays. Of those five reports, three were rejected and two were accepted for assessment. During this seven-month time period, other events and issues also occurred with the Rays that were significant to our investigation.

APRIL 10, 2014

Three different units within DHS were involved in the April 10, 2014, allegations of abuse: child abuse intake and assessment, daycare licensing, and foster care licensing.

1. Accepted intake and assessment (not confirmed)

DHS received a child abuse report regarding Sabrina (then age 13) and her two sisters (then ages 9 and 7) on April 10, 2014, from the mother of a child who was formerly in foster care with the Rays. The call was made during business hours and handled by a Centralized Services Intake Unit (CSIU) worker.

The audio recording for this call shows that the mother had a number of concerns about the three adopted siblings, and indicated that the information came from her son. The mother relayed her son's allegations that the girls did not get fed for weeks at a time and were made to sit on the floor and watch everybody else eat. The mother stated that the oldest (Sabrina) resorted to sneaking food from the trash to feed her siblings. She also shared that Marc and Misty had made the three girls fight over a Twinkie and referred to the battle as their "entertainment time."

The mother also relayed her son's allegation that Marc and Misty physically abused Sabrina in the basement, and that there was video footage of one of these incidents. The injuries reported were bruises, cuts, and bloody noses and lips.

The mother told the intake worker that she worried about the safety of other children in the home, as the Rays had a number of children in the daycare.

The intake document classified the allegations as "physical abuse" and "denial of critical care."

According to the intake call, the worker told the mother that the preliminary decision was to accept the report for an assessment. The intake report documents that Social Work Supervisor (SWS) Mike Allison reviewed the intake report and made the final decision to accept the report for a child abuse assessment.

The assessment was handled by a DHS field worker. According to the child protective assessment summary, she made an unannounced visit to the Ray home the same day the report was received.

The worker interviewed Sabrina and her sisters alone. The children denied that Marc, Misty, or anyone else had ever hit them or made them fight each other for food. They also denied that they

had to steal food or were made to stand for long periods of time as punishment.[85] Instead, they stated that they were given three meals and two snacks each day, and were made to sit in time out when disciplined.

The field worker documented in the assessment summary that she spoke with Misty regarding the allegations, and Misty shared that all three girls "have past food issues in their families of origin." Marc and Misty denied restricting food from the children or making them fight for food. As for punishment, the Rays indicated that they typically used time outs, but there had been a few occasions in which the children were "swatted on their bottoms" with an open hand, over their clothing. Marc and Misty specified that disciplinary swats would not leave a mark.

While at the home, the worker also spoke with Sabrina's minor adopted brother, who stated that food was not restricted, nor were his siblings made to fight for food. He did indicate that he was scared of being spanked and that his sisters would be spanked, but said that no one "had marks from being hit."

She also spoke with Justin Ray, Misty's biological son, who stated that the girls were not beaten, nor were they treated any differently.[86]

The worker then contacted the DHS ongoing-services worker, Marcia Hoffman, for additional information on the family. Hoffman at the time was working with the family concerning three foster care children who were placed with the Rays. According to the child protective assessment summary, Hoffman reported that she had made unannounced visits to the home and had never seen any food being withheld or maltreatment of the children.

During the course of the assessment, the field worker contacted several collateral witnesses, including the former foster child whose mother made the report, as well as the former foster child's grandparents.[87] It was reported by the former foster child that he had never seen a video of any abuse, nor did he have any concerns about the Ray children.

She made an additional collateral contact with the foster care support worker for the Ray family, who reported that she had worked with the family for more than a year and had made both announced and unannounced visits to the home. No concerns were noted about the care of the children.

According to the assessment summary, the worker made a phone call to a confidential informant

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[85] The allegation of the children standing as punishment was not made during the April 10, 2014, intake call. This allegation was made in subsequent reports to DHS on April 24, 2014; May 7, 2014; and on November 25, 2014. It is not clear whether the field worker asked a question specific to whether the children had to stand as punishment, or if the children offered this information.

[86] Justin would later plead guilty to two counts of willful injury against Sabrina following her death. Kiley Wellendorf, *Justin Ray sentenced to 10 years in prison following death of Sabrina Ray*, Perry Chief, February 16, 2018. "In court, Ray admitted to pushing Sabrina Ray down a flight of stairs, causing bleeding to her head. Ray also admitted to kicking Sabrina Ray in the head, causing a cut on her chin."

[87] According to DHS policy, field workers are instructed to interview anyone who is familiar with the child and family who can provide additional information. DHS's Employees' Manual, Title 17, Chapter B(1), Page 32a. For a detailed analysis regarding identifying and contacting collateral witnesses, see Pages 59 – 62 in the Ombudsman's investigative report on the Finn case, "A Tragedy of Errors: An Investigation of the Death of Natalie Finn," available at https://www.legis.iowa.gov/docs/publications/CI/1130515.pdf.

to discuss the allegations. We received no information regarding who the informant was or the details of the discussion.

The field worker made a second unannounced home visit to the Rays' on April 30, 2014. She documented that "Sabrina [and her sisters] were happily interacting with the daycare children. They were getting ready to have a snack with the daycare children and seemed happy and well-bonded to Marc and Misty."

This child abuse report was the second report received by DHS in a six-month period which had nearly identical allegations of physical abuse and failure to provide adequate food to the adopted daughters.

The case was staffed with a supervisor, and the ultimate determination was a finding that the physical abuse and failure to provide adequate food allegations were not confirmed. The worker submitted the findings of the investigation to her supervisor on May 5, 2014, and the child abuse assessment was signed by the supervisor and closed two days later.

This child abuse report was the second report received by DHS in a six-month period which had nearly identical allegations of physical abuse and failure to provide food to the adopted daughters.[88] The reports were made by two different individuals.

2. Daycare licensing referral

A referral to DHS's daycare licensing unit was also made on the same day the child abuse report was made. The referral was required under DHS policy so the licensing worker can "focus on compliance issues with the child care law and the requirements for registration."[89]

The daycare licensing worker made an unannounced compliance and spot-check on the Ray home on April 16, 2014. In addition to interviewing Marc and Misty, the daycare licensing worker reviewed meal plans, reviewed discipline policy and practices, observed current food supply on hand, and looked over the posted menu for the monthly lunches. It was noted in the complaint documentation that "the cupboards and refrigerator were both stocked with appropriate and nutritious supplies for a healthy diet."

The daycare licensing worker also observed some daycare children engaged in free play, while others were getting ready for a nap.

Ultimately, the daycare licensing worker determined that there was no evidence consistent with the reported complaint. He wrote, "I have no evidence to indicate providers are out of compliance with policies related to nutrition and disciplinary practices. I have closed out my complaint investigation."

[88] The first report was received on September 20, 2013, by the FSRP services worker.
[89] DHS's Employees' Manual, Title 12, Chapter F, Page 64.

3. Foster care license placed on "hold" and April 11, 2014, staffing

A DHS foster care licensing worker received notification of the April 10, 2014, accepted intake and made the decision to place the Rays' foster care license on "hold." He emailed a notification to staff at Iowa Kids Net that the Rays were placed on hold due to a child abuse assessment with "lots of allegations."

At the time of the April 10 accepted intake, there were three siblings in foster care with the Rays. The children – "the Millers"[90] – were placed with the Rays on April 4, 2014, just six days prior to the child abuse report.

The following day, a staffing was held between a foster care licensing worker and supervisor, the DHS ongoing-services worker handling the Miller foster care placement and her supervisor, and the field worker assigned to the April 10 assessment and her supervisor. According to DHS's Confidential Briefing:

> Licensing questioned if foster children should be moved. Ongoing worker Marcia Hoffman, CPW supervisor Jennifer Carlson and ongoing supervisor Mark Chappelle thought they should remain. Plan developed during licensing staffing that they cannot use physical discipline with foster children or day care children.[91]

The April 11 staffing confirmed that the Rays' foster care license would be placed on "hold" for future placements, but the Miller children would not be removed from the placement – essentially, there would be no additional placements unless the "hold" was lifted.

During an interview with us, former DHS supervisor Mark Chappelle stated that, though he does not recall advocating for the Miller children to remain in the Rays' foster home, he trusted the ongoing-services worker, Hoffman, to look out for the children. He explained his thought process: "I think we can protect these kids, I think we can keep a close eye on them – we don't want to disrupt those kids again. I think that's probably why we did that."

Chappelle also provided us with an explanation for the decision to place a "hold" on a foster care family: "There's something happening there, we don't know what it is – we can't prove it … don't have enough for a suspension or revocation – but we're not going to place any more kids there."

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[90] For confidentiality purposes, we have created a pseudonym for this family.

[91] Notably, this "plan" that was developed is more of a recitation of the Iowa Code 234.40, regarding corporal punishment:

> The department of human services shall adopt rules prohibiting corporal punishment of foster children by foster parents licensed by the department. The rules shall allow foster parents to use reasonable physical force to restrain a foster child in order to prevent injury to the foster child, injury to others, the destruction of property, or extremely disruptive behavior. For the purposes of this section, "corporal punishment" means the intentional physical punishment of a foster child. A foster parent's physical contact with the body of a foster child shall not be considered corporal punishment if the contact is reasonable and necessary under the circumstances and is not designed or intended to cause pain or if the foster parent uses reasonable force, as defined under section 704.1.

Regarding DHS's administration's involvement in the decision to place the Rays' license on "hold" for future placements, DHS shared that "licensing staff were directed by SAM[92] Pat Penning that this home was not to be used and would not be used in the future."

The Rays remained on "hold" status for almost two years until their foster care license was officially closed on January 28, 2016 – 16 months before Sabrina's death. According to DHS, the license was closed on this date because the Rays chose not to renew the license.

The Rays remained on "hold" status for almost two years until their foster care license was officially closed on January 28, 2016.

APRIL 24, 2014 REJECTED INTAKE

While the prior child abuse assessment was still active, DHS received another child abuse report regarding one of the Miller children on April 24, 2014, from FSRP services worker, Shelby Messersmith. This was the third report that Messersmith had made concerning the Rays in the past seven months.[93] The intake call was made during business hours and was handled by a CSIU worker.

Messersmith explained during the call that the foster care child reported to her that Marc and Misty were forcing him to eat food he did not like, which made him throw up in his mouth. The child had told her that the Rays would not allow him to go to the restroom when he threw up, and instead made him either swallow it or throw up on his plate and eat it. She also indicated that the child was not given anything other than water to drink.

During the call, Messersmith told the intake worker that the Miller children eat a lot of food during their visits with their biological mother. She shared that one of the children's teachers indicated that the child eats "tons of food" while he was at school. Messersmith stated that "they are chunkier children," but it appeared that the alleged child victim may have lost some weight since being placed with the Rays.

Messersmith stated that Marc and Misty no longer allowed her to come into the home … which caused her more concern about the safety of the children.

Messersmith also reported that the child shared that when his 4-year old brother had accidents in his pants, Marc and Misty made him stand in the corner all day.

While making the report of child abuse, Messersmith shared some of her own personal experiences with the Rays. Marc and Misty no longer allowed her to come into the home when she dropped the children off after visits, which caused her more concern about the safety of the children.

Messersmith recounted that the previous day, she was denied entry into the Ray home following a visit with the Miller children. She described this incident in a FSRP report dated May 9, 2014:

[92] SAM refers to Service Area Manager.
[93] The first report Messersmith made was on September 13, 2013, and second report was on September 20, 2013.

"When FC[94] got to Marc and Misty's, Marc was at the door standing in the doorway so FC could not walk inside. Marc made FC stand in the rain and drop the children off." In the same FSRP report, Messersmith documented a later visit with the children on April 30, where Marc again refused to allow her inside the home: "When FC dropped the children off, Marc was standing in the doorway again and would not let FC come inside."

When we interviewed Messersmith, she shared additional details about this concern. She explained that when she first began working with the Rays, she was allowed into the home which she described as "quiet, super clean, and neat." Marc and Misty later began refusing her access inside the home; this hindered her ability to fulfill her job duties of ensuring the safety of the children in the foster home.

Messersmith indicated during the child abuse call that she had shared these concerns with the DHS ongoing-services worker, Marcia Hoffman, as well. Asked whether she felt her concerns were taken seriously by Hoffman, Messersmith told us that she felt the safety concerns were "brushed off." Documentation received from Mid-Iowa supports Messersmith's recollection of Hoffman's response. On April 24, 2014, the same day as the child abuse report, Messersmith wrote an email to her supervisor, Susan Smalley, stating that "Marcia was not thrilled that I was calling it in, so I do not feel like she will give them the necessary updates."[95]

We found no information in Hoffman's case notes about Messersmith's inability to gain entry into the Ray home. Further, when we questioned former DHS supervisor Mark Chappelle about the Rays not allowing Messersmith in the home, he could not recall receiving notice about the issue. Chappelle admitted that this should have been particularly concerning: "I would like to think that if I knew about that, there would be some discussion directly with Marc and Misty – you can't do that, you're going to do foster care, we're coming in."

We found no information in Hoffman's case notes about Messersmith's inability to gain entry into the Ray home.

Nevertheless, Messersmith's April 24, 2014, child abuse report was rejected. According to the audio recording of the intake call, the worker indicated to Messersmith that she did not believe the information provided rose to the level of child abuse. Additionally, the intake worker confirmed with Messersmith that there was no information to suggest that the children had articulated that they were being denied food at the Rays.

The intake worker made a preliminary decision to reject the intake, and this decision was confirmed by SWS Amanda Kuhl.

In a section of the intake report titled "Rejection Explanation," the intake worker chose "Insuff. reason to suspect child denied adequate care." According to the intake document, the case was referred to Hoffman as the Miller's ongoing-services worker, and to the foster care licensing worker. We found no indication the intake report was forwarded on to the field worker who was

[94] "FC" refers to FSRP worker, Messersmith.
[95] Based on the content of the email, we believe that "them" is referring to the biological mother of Miller children and the mother's attorney.

still working on the assessment from the April 10 report, and there is no reference in the child abuse assessment of this intake.

MAY 7, 2014 REJECTED INTAKE

DHS received a child abuse report on May 7, 2014, from an adoptive parent of a former foster care child of the Rays. This was the third child abuse report made concerning Marc and Misty's care of the child while she was in foster care placement with them.[96] It was received on the same day the April 10 assessment was closed. The intake was handled by a CSIU intake worker.

This was the third child abuse report made concerning Marc and Misty's care of the child while she was in foster care placement with them. It was received on the same day the April 10 assessment was closed.

The audio recording for this call shows that the reporter had concerns about the Rays' treatment of the child while she was placed with them through foster care. The reporter stated that the child told the adoptive parents some of the things that happened to her while at the Rays' home.

It was reported that the former foster care child was subjected to certain punishments, such as drinking soapy water and water with spices in it, as well as standing all day either against a wall or over a cold vent. The reporter explained that the latter punishment was particularly disturbing because the child had a heart condition that caused her to have poor circulation and curled toes, which would make it difficult and painful to stand for long periods of time. The intake report documented that the child said that "whenever a DHS worker would come, the punishment would stop until he left and it would resume when this worker left."

"Whenever a DHS worker would come, the punishment would stop until he left and it would resume when this this worker left."

The reporter also stated that the child told her Marc and Misty would make her go without meals. She would get breakfast, but then would not receive lunch or dinner (though she never went a whole day without food).

It was also shared that the Rays made the child bite her sister, and they would start laughing in response. Additionally, another child in the home would hit other children with plastic bats.

She told her adoptive parents that Misty had directed her to lift a daycare child, but she could not manage the weight and ended up dropping the baby. As punishment, the child had to skip a snack.

The intake worker asked the reporter whether the former foster care child ever had any physical injuries or illnesses resulting from the punishments the Rays imposed. The answer to this was no. The intake worker asked when the child got a physical, whether she was identified as being

[96] The first child abuse report received regarding this child was on October 15, 2010, and the second report was received on November 2, 2010. These reports were discussed in a preceding section of this report.

underweight or emaciated. The reporter indicated that she was not.

It was also documented that the reporter could not provide specific dates, but that the child had been placed in foster care with the Rays in 2010 and 2011.

The intake document identified the allegation as "denial of critical care." During the call, the intake worker indicated that, although the issues she identified were concerning, she did not believe that it would be accepted as an assessment. She made a preliminary decision to reject the intake and consulted with SWS Mike Allison, who made the ultimate determination to reject this intake.

In a section of the intake report titled "Rejection Explanation," it states, "Insuff. reason to suspect child denied adequate care."[97]

Under the "Rejection Reason," the intake document states that the case was referred to the foster care licensing worker. We found no evidence that the information was referred to the daycare licensing worker, or that it was shared with the field worker whose child abuse assessment was closed the same day.

We found no evidence that the information was referred to the daycare licensing worker, or that it was shared with the filed worker whose child abuse assessment was closed that same day.

MAY 2014 STAFFING

A DHS foster care licensing worker received notification of the May 7, 2014, rejected intake the same day the report was made. He emailed foster care licensing supervisors, Ann Williams and Nancy Thompson, stating that he was "surprised this was rejected." Williams also expressed her surprise that the intake was rejected, as she claimed to have told the adoptive mother to make the report to DHS.

After notifying the supervisors, the foster care licensing worker then sent an email to Hoffman and her supervisor, Mark Chappelle. At that point, former social work administrator (SWA) Mike McInroy was also aware of the allegations, as the licensing worker stated in his email that McInroy had asked to interview the Rays' current foster care children to assure their well-being. The worker also noted, "the food issue continues to be a consistent reported concern."

Thompson emailed Chappelle on May 9, indicating that she had talked to McInroy who clarified that Hoffman needed to interview the children and be "specifically asking the questions surrounding the intake. For example, using food as punishment, not feeding them, etc." McInroy also requested that Hoffman contact the service providers, which would have included Mid-Iowa FSRP worker Messersmith.

Referring to McInroy, Thompson stated that "Mike is really concerned."

[97] According to the intake document, the call was received at 9:19 a.m., and the rejection decision was made at 9:20 a.m. on May 7. The call length, however, was 23 minutes and 38 seconds, so the total elapsed time according to the intake document does not appear to be correct.

Hoffman emailed Chappelle on May 12 stating that she had interviewed two of the current foster care children at their respective schools. Hoffman documented her interview as follows:

- "When school is over for the day he returns to the Ray foster home and has a snack and drink such as cookie, crackers, fruit. At night the family sits (at the) table and eats. He mentioned his favorite meal of chicken, mashed potatoes with corn on the potatoes. He also likes spaghetti, hamburgers and hot dogs. On weekends they have eggs, cereal, or donuts for breakfast. When he gets in trouble he goes to time out for a short time."
- "[The child] reported Misty is a good cook and makes cheese burgers, spaghetti, meatballs, chicken and tacos. When he gets in trouble he goes to time out for a short time."
- "The Headstart teacher reported [the child] eats breakfast and lunch at Headstart. He usually has two bowls of cereal instead of one in the morning and second helpings at lunch."
- "This worker observed it appears [the child] is gaining weight."

Chappelle emailed a response to Hoffman the same day, asking whether she could cover specific areas of concern identified in the May 7, 2014, rejected intake. Chappelle listed the following concerns, and questioned whether Hoffman had asked the children about the allegations:

- "(Prior foster child) said that as punishment that they had her drink water with soap or spices in it or stand all day against a wall or a vent or for hours."
- "She was not allowed to go to bed until Mark (sic) and Misty went to bed."
- "Mark (sic) and Misty required her to bite a sibling, at first she refused and then Misty yelled at her to continue this and did."
- "There was another child in the home … that was allowed to strike them with plastic bats."

To our knowledge, there was no further correspondence following up on Chappelle's email.

Hoffman responded that she had not covered those specific issues and had not known to do so until after she had visited the children.

However, we interviewed Hoffman and asked pointedly whether she had asked the children about the allegations from Chappelle's email. Hoffman responded that she did not cover those specific issues and had not known to do so until after she had visited the children. Hoffman said she only asked whether the children were getting enough to eat, what time they went to bed, what they did every day, and when they showered. Asked whether Hoffman responded to her supervisor's email, she stated, "I took care of my three [Miller children], but no I did not."

When asked to elaborate on her visit with the foster care children, Hoffman stated that they were not "slender children" and "looked healthy."

We also received no information to suggest that Hoffman had contacted the service providers, as directed by the SWA McInroy.

We also received no information to suggest that Hoffman had contacted the service providers as directed by SWA McInroy.

During our interview with Chappelle, he said that Hoffman's response surprised him: "Marcia was a pretty straight arrow, you tell her to do something and she did it." Chappelle stated that he was unaware Hoffman had not asked the specific questions or failed to contact the service providers. We asked whether there was any follow up with Hoffman concerning her findings by anyone involved in the May staffing, particularly McInroy who was reportedly "really concerned." Chappelle stated: "If Mike was that excited about it, we were going to do what we needed to do, whatever we were directed."

DHS's Confidential Briefing indicates that Hoffman and Chappelle conducted a joint home visit to the Ray home following the May 7, 2014, rejected intake. There is no documentation regarding any such visit in Hoffman's case plan notes. When we asked Hoffman about this visit, she told us that she did not recall this happening. Similarly, Chappelle could not recall any such visit.

JUNE 12, 2014, BRUISING

FSRP worker Shelby Messersmith visited the Miller children at their biological mother's home on June 12, 2014, where she documented bruising on the youngest sibling. Messersmith was concerned that the bruising was the result of abuse that occurred at the Rays. The FSRP report stated:

> **[The mother] showed FC[98] a series of bruises that were on [the child]**. [The mother] stated that they were deep bruises and she wants to know where they came from. FC informed [the mother] that she is allowed to ask Misty those questions and that Misty might know exactly what happened or they could be from the kids playing. [The child] was very uncomfortable when laying on the ground as [the mother] was showing FC the bruises. [The child] kept saying, 'don't hurt me, don't hurt me.' as she was crying. FC advised [the mother] to talk with Marc and Misty about the bruises to see what they had to say. **[The child] communicated to FC that one of Marc and Misty's daughter's hurts her. FC talked to Marc and Misty about it and they stated that their daughter is very caring and would not hurt anyone**. [The mother] talked to Marc and Misty about it and they were defensive and stated that they were not going there with her and they didn't know [the child] had bruises on her. FC made sure that all parties were aware of this situation. (Emphasis added.)

[98] "FC" refers to FSRP worker, Messersmith.

Messersmith believed there was a strong chance that the bruising was inflicted by the Rays. Asked to describe the physical injury, Messersmith reported to us that the bruising was up her back and thigh, not in common "play areas" such as on a child's knee.

Messersmith believed there was a strong chance that the bruising was inflicted by the Rays.

Messersmith stated that she went to her supervisor, Smalley, regarding the bruising on the child, but was told that she could not make a child abuse report to DHS.

Messersmith stated that she went to Smalley regarding the bruising, but was told she could not make a child abuse report to DHS.

Messersmith told us that she also raised the concerns about the Rays with ongoing-services worker Hoffman; however, she never felt like she was taken seriously. Specifically, Messersmith recalled notifying Hoffman about the bruising issue from the June 12, 2014, visit. Although Hoffman did not document this conversation in any case notes that we received, she did document a number of instances in which she had communicated with the biological mother's attorney regarding the concern.

Hoffman's case notes from June 16, 2014, included an email from the attorney that read:

> We NEED to get the children out of Misty and Marks (sic) this week!!! I had a long talk with Shelby [Messersmith]. [The child] has unexplained bruising. … I will make closing this daycare down if they aren't removed. ... Mark (sic) and (Misty) are emotionally abusing and physically neglecting [the mother's] children. I don't doubt it for a minute.

On June 17, Hoffman documented a call with the attorney:

> She wants the children removed and returned to [the mother]; **Shelby [Messersmith] told her about the bruises and Shelby's supervisor would not let her call it in to CPA**. … discussed that the daycare worker, CPA, this worker had all been to the home or interviewed the children and there was no evidence or abuse or neglect in the home. (Emphasis added.)

The same day, Hoffman documented a meeting she had with her supervisor, Mark Chappelle, and Tracy White, DHS Social Work Administrator (SWA): "Met with supervisor [Chappelle]; conference call with Tracy White; Shelby [Messersmith] to find out about the bruises then meet with her supervisor and call into CPA Intake if there is enough evidence to report."

On June 19, Hoffman documented in a case note the following conversation with the biological mother's attorney:

> Informed her DHS would not be moving the children from the Ray foster home; informed her Shelby asked Misty about the bruises on [the child]; **[Shelby] then talked with her supervisor and the concern will not be called into CPA Intake**. (Emphasis added.)

Though Hoffman documented conversations with others regarding the bruising concern, there is no indication she visited the children in response to those concerns. Hoffman's case notes document that a visit occurred on June 4, 2014, and the next visit did not occur until August 1, 2014.

Following the mid-June bruising allegations, DHS and Mid-Iowa coordinated a meeting attended by Chappelle, Smalley, and Messersmith. Smalley mentioned the meeting in an email to Mid-Iowa Family Preservation and Stabilization Services Director Lori Mozena on June 18, 2014:

> Talked with Mark Chappelle this morning. We are going to go ahead and meet on Friday to discuss the situation. He agreed that a '**public flogging**' was not necessary but that Shelby did need to hear from the DHS end as well as the position she put herself because of this situation. He's not requesting a new worker and will support whatever we choose to do staffing wise. Now just keep your fingers crossed that mom's attorney let's the situation drop and doesn't push it in court…..! (Emphasis added.)

To us, Smalley described the meeting as a productive conversation, one in which she believed they had all left feeling on the same page. She wrote in an email to Mozena on June 20, 2014, that the meeting with Messersmith and Chappelle "went well."

Messersmith had a different recollection of the meeting. She reported to us that she was completely blindsided by the meeting. She believed that she would be able to address the concerns that she had on the family, but instead, she was verbally reprimanded for raising the concerns. Messersmith stated that the message from the meeting was clear: "Do your visits and shut up." Asked whether Smalley or Chappelle had actually told her not to make any more reports at this meeting, Messersmith clarified that they did not; however, she was told that the Rays had informed DHS that if she were to continue to raise concerns there would be legal harassment charges brought against her.

Messersmith stated that the message was clear: "Do your visits and shut up."

We asked Smalley if she recalled a conversation during the meeting regarding the Rays pressing legal harassment charges. She replied, "No, I have no recollection of that." Asked whether he recalled this conversation, Chappelle shared that it sounded familiar, and it definitely seemed like something Marc and Misty would have been capable of pursuing because "apparently they had a lot to hide."

Messersmith left her job as an FSRP services worker with Mid-Iowa in July 2014, shortly after her meeting with Chappelle and Smalley. Messersmith stated she thought she was doing good by raising the concerns, but she "wasn't doing good anymore," so she had to go. She told us that she felt "defeated."

JULY 5, 2014 ACCEPTED INTAKE AND ASSESSMENT (NOT CONFIRMED)

DHS received a child abuse report regarding the youngest Miller sibling on July 5, 2014, from the child's biological mother. The reporter alleged that Marc and Misty "spanked, smacked, slapped" the 2-year old, which resulted in bruising. The report was made 23 days after Messersmith had witnessed bruising on the child and was directed not to report the suspected physical abuse to DHS.

The child abuse call to DHS was made on a Saturday, so it was not handled by the Centralized Services Intake Unit (CSIU). Instead, the call was handled as an after-hours intake by a DHS field worker.

The field worker's intake document identified the allegation as "Physical Abuse." He wrote, "Reporter states that [the child] is spanked, smacked, slapped and put in timeout when she has accidents in her pants. [The child] has bruising on her bottom and back as a result of physical discipline by the foster parents." The intake was accepted for an assessment.

After handling the intake call, the worker was initially assigned to handle the assessment. He conducted a home visit the following day, on July 6. According to the child protective assessment summary, he called the Rays 10 minutes before he arrived for the home visit to let them know he was coming.

The field worker observed the child at the Rays' and concluded that there were "no visible injuries consistent with the allegation reported." It was documented that there was a "faint scratch on her lower back from her pull-ups," which was the explanation the Rays provided. They told the worker they had not used any form of physical punishment when disciplining the child and her siblings.

Following the home visit, the case was transferred on July 7 to another DHS field worker. This worker visited the biological mother's home and checked on the girl and her siblings. He documented that there were "no visible injuries on the children." During the visit, the mother stated that the older children told her that Marc and Misty spanked the youngest sibling "all the time." However, she could not provide the field worker with a specific incident when an injury was sustained as a result of the discipline.

When the children were interviewed, they reported that they liked the Rays and indicated that they do not receive physical discipline.

The field worker also contacted ongoing-services worker Hoffman, who shared that she saw the children regularly and they had reported to her on several occasions that they liked staying at the Rays' home.

Hoffman could not recall during her interview with us whether she relayed Messersmith's allegations about the child's bruising the month before. Hoffman had previously documented in her case plan notes a number of communications with the biological mother's attorney, which described Messersmith's observations of bruising on the youngest Miller sibling, and alleged that

the injuries were inflicted by Marc and Misty – the same allegations that were made in the report being investigated.

Hoffman had also received an email from Misty on July 7, 2014, regarding the initial home visit by the DHS field worker. Misty stated in the email:

> We got a visit from a CPS worker yesterday about [the child]. It was turned in that we were spanking her for not using the potty and if she has accidents in her pants. And that she was covered in bruises. When the gentleman spoke to all three kids they told them the only type of discipline that we use here is time outs and when he checked her for bruises there was only one tiny bruise on her knee and a small almost gone bruise right behind her knee. I am not sure where the allegation comes from, but I can imagine it was [the mother] because she has complained about bruising on [the child] before from our oldest daughter a few weeks ago and her respite provider when we sent the kids there on graduation weekend.
>
> There is a spot on [the child's] back that is yellow, she has had this same spot since May. **It was the spot she said [the child] got at respite and has also told Shelby that she got at our house. It is not a bruise, but some sort of skin discoloration**. The worker left with no concerns. (Emphasis added.)

According to Hoffman, she did not share this information with the field worker, even though it appears that the information was received prior to her contact with the field worker.

The child abuse assessment does not indicate that either of the field workers contacted Messersmith.

Ultimately, the physical-abuse allegation was determined to be not confirmed.

We found no indication that daycare licensing staff were informed about the child abuse report, as required by DHS policy.

JULY 9, 2014 STAFFING

On July 8, 2014, a DHS foster care licensing worker received notification of the July 5 child abuse report made against the Rays. In response, he emailed Iowa Kids Net to confirm that the "hold" was still in place on the Rays' foster care placements.

According to DHS's Confidential Briefing, a staffing was held the next day between the foster care licensing worker and a supervisor, and the field worker who was reassigned the handling of the assessment, and his supervisor. The document notes that "no bruises (noted), children verbalized no concerns and Marcia Hoffman had no concerns."

No further action was taken regarding the foster care placement of the Miller children with the Rays. After the child abuse report was made – the second involving the Millers, among the numerous concerns raised by Messersmith – the foster children remained in the home for an additional 23 days. The children were ultimately reunified with the biological mother on

July 28, 2014. This was the last time the Rays had foster children placed in the home.

ADMINISTRATION'S REVIEW

DHS Service Area Manager (SAM) Pat Penning conducted a review of the family for the second time on July 30, 2014. Penning sent an email to DHS SWA Mike McInroy asking that he take a closer look at the family because "the number of assessments and rejected intakes is concerning." Penning requested that McInroy review the following information: "Why do they keep getting referred? Who are the reporters? Is there a pattern? What are we missing?"

There is no indication from DHS records that any further discussions on the issue took place for nearly two months. Penning wrote an email to McInroy on September 30, 2014, that she had not received McInroy's findings of the family and asked that he bring the information to their next one-on-one meeting.

When we interviewed Penning, she could not recall sending the emails, nor could she recall the response she received from McInroy during their one-on-one meeting. Penning also could not recall what decision was made or what future steps, if any, were taken.

NOVEMBER 25, 2014 REJECTED INTAKE

DHS received a child abuse report regarding one of Sabrina's sisters (then age 10) on November 25, 2014, from an anonymous reporter who had previously taken her daughter to the Rays' daycare. The call was made during business hours and was handled by a Centralized Services Intake Unit (CSIU) worker.

According to the reporter, her daughter told her that Misty would hit Sabrina's sister and always told the daughter to close her eyes. It was alleged that the child had a bruise on her neck when the caller saw her.

The reporter also stated that the child victim and Sabrina were "always standing" in the home, and on one occasion, the reporter saw the child standing for a lengthy period of time. The reporter also mentioned that she believed Sabrina and her sister were being mistreated by Misty, and made to work for the daycare.

The reporter also shared concerns about the child's weight, telling the intake worker that the child is "very, very, very thin, she's very small … I wonder if she's not eating right.

The reporter shared concerns about the child's weight, telling the intake worker that the child is "very, very, very thin, she's very small … I wonder if she's not eating right."

The intake document identified the allegation as "Physical Abuse."

According to the intake report, the intake worker consulted Kate Oberbroeckling, a Social Worker 4 (SW4, also referred to as a "lead worker"), who made a preliminary decision to

reject the intake. SWS Mike Allison subsequently reviewed the intake report and made the final decision to reject it.

In a section of the intake report titled "Rejection Explanation," it states, "Insuff. reason to suspect physical injury resulted."

ANALYSIS

Thoroughness and accuracy of intake reports

An integral part of an intake worker's job is to produce a complete and accurate record of a reporter's allegations and the surrounding circumstances. The clearest enunciation of this standard is contained in CSIU's "Intake Evaluation Tool," which declares that the goal is to have "no discrepancies … between (the) caller's statements and what is documented" in the intake report. Intake workers are instructed to document the allegation as stated by the reporter – as opposed to a synopsis – and to write in complete sentences.[99]

Intake workers are also instructed to record necessary information and discern between significant and extraneous information.[100] During our investigation into the death of Natalie Finn, we discussed this policy with SAM Lori Lipscomb,[101] who told us, "I think we have to define 'complete.' I don't know that you can capture verbatim every word." We agree with Lipscomb – the expectation should not be unattainable perfection, but rather, to document as much relevant information as possible, within reason.

We obtained and reviewed the available recordings for the intake reports involving the Rays. For the most part, the intakes were documented appropriately. However, we found two instances where significant information was shared by the reporter, but was not documented in the intake report.

A. April 24, 2014 intake

We found one issue concerning the thoroughness and accuracy of the CSIU intake worker's documentation of the April 24, 2014, intake call. Messersmith made the following comments during the intake call, referring to what the foster care child had reported to her:

> Misty and Marc were making him eat food that he did not like, so he was eating it and threw up in his mouth. He said he tried to get up from the table to go to the bathroom to the toilet to throw up and they made him sit there and told him he could either throw up on the plate, and then he had to eat it, or he had to swallow what was in his mouth.

Messersmith stated that she asked the child what he ended up doing, and the child reported that he had swallowed what was in his mouth.

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[99] DHS's Employees' Manual, Title 17, Chapter A(1), Page 6.
[100] DHS, *Child Abuse – A Guide for Mandatory Reporters Guide*, July 2019, Page 32.
[101] At the time of our interview, Lipscomb was the Service Area Manager of the Centralized Services Area, which includes CSIU.

The intake worker wrote in the intake document: "It is alleged that the child vomited in his mouth and the foster parents told him to either swallow it or throw up on the plate but would not allow him to go to the bathroom." Under "Additional Information" on the intake document, the worker wrote, "Misty and Mark (sic) were making him eat food that he didn't like it. He threw up in this mouth, he tried to get up from the table to go to the bathroom. Throw up on the plate or swallow the puke that it was in his mouth."

It was not documented that the child was only given the option to swallow what was in his mouth, or spit it out on his plate *and eat the vomit.* Additionally, the intake document does not mention what the child ultimately did – swallowed the vomit.

B. November 25, 2014 Intake

We identified a number of concerns with how this intake was handled. The following table compares recorded statements made by the anonymous reporter during the phone call and what was captured in the intake report:

November 25, 2014, Intake Call from Anonymous Reporter

Anonymous reporter's statement	Intake report
"There was a time I was working at 4 in the morning, and throughout the year that I've been taking my kids there, I've worked different hours, so I've been there throughout different times of the day and the children are **always standing**. The two girls, Sabrina and [Sabrina's sister]. (Emphasis added.) "And the girl [Sabrina's sister] … **Every time I go there when the other kids are napping, she's awake, standing."** (Emphasis added.) "But I noticed [Sabrina's sister] standing, and it looked from the outside of the window like her mom's face – Misty – looked like she was saying something to her in an angry way. Well she was standing, and so I sat and waited to see how long she would stand and I ended up going in at … 9:47, **so from 9:30 to 9:47 she was just standing."** (Emphasis added.)	"Tuesday the 4th of November at 9:30 caller pulled up to the home and saw misty yelling at [Sabrina's sister]. Misty made [Sabrina's sister] stand as punishment."
"And the girl [Sabrina's sister], I think she's about 13 or 14, **but she's very, very, very thin, she's very small, she looks like she's about 8 or 9 years old. So I wonder if she's not eating right**, and she's always had bags under her eyes because she's always awake." (Emphasis added.)	*This statement was not documented.*

"So when I went inside to get my kids … I looked around the corner at [Sabrina's sister], and it looked like her eyes were red, like she had been crying, and she was standing with a crate – standing with a plate of pizza, eating it. And I just thought it looked kind of – just something wasn't right about the situation." "And it looked like she had a bruise on her neck."	"Caller states that it appeared [Sabrina's sister] had a bruise on her neck when she went into the home."
"I said okay, I said, 'Is that all, did something happen to [Sabrina's sister]?' She said, 'Yeah.' I said, 'Did Misty do something else to [Sabrina's sister]?' And she said, 'Yeah but I have to close my eyes.' I said, 'What happened?' I said, 'Did she hit her?' And she said, 'Yeah.' I said, 'Did you see it?' She said, '**No because she always told me to close my eyes every time**.' That's what she said." (Emphasis added.) "And I waited to report it because I didn't actually see the abuse myself it's more of a suspicion, and I just kinda wanted to talk to some of my old – you know, just run it by a couple people."	"Callers daughter who is 5 said that Misty told her to close her eyes and then she heard her hit [Sabrina's sister]. It is unknown if this is specifically where the bruise came from at this time. It is alleged that Misty may have hit [Sabrina's sister] (age 10), It is unknown if any injury was caused. Physical abuse is alleged."
"But I really think that even though if I didn't see it and I'm not sure, I think that those children are not – **I think that they're being mistreated. I think they are being used as – whenever the kids get up from the naps,** [Sabrina and her sister] **have to fold the blankets, they have to get the kids awake, they have to clean up, they have to do things that children are not supposed to be doing**, and I think that there's something going on." (Emphasis added.)	*This statement was not documented.*

"I just think that my main concern – and I can't tell you guys how to do this assessment – but I think that the children, they won't tell you right away, you know what I mean? I think that they have been in that situation for so long, that they – if someone goes in there and just asks questions, or asks her it's going to appear to be a certain way because **I know that they've been trained – I mean for lack of better words – trained to do what they've been doing there for awhile**, so I think that they may need to be away from the parents if they're going to be questioned or talked to." (Emphasis added.) "I really think that it's important that whoever goes there is really trained to look for – you know, behavior with these children, their facial expressions, their body language, and all that because I can see it, and I just go there throughout and it could be easy for someone to go there and talk, and then not see anything and then leave."	*These statements were not documented.*
But I really feel – like I've said I've been taking them there for a year – **I really feel that those children are just very afraid and they're being abused and they're being neglected."** "And she said that [Sabrina and her sister] are scared all the time too." "**But I think that those children are very, very, very, very afraid of their parents – very afraid**." (Emphasis added.)	*These statements were not documented.*

It is evident that the intake report omitted several important elements of the information shared by the reporter relating to child abuse. We believe these omissions contributed to the failure to document another child abuse allegation – "denial of critical care."

Decision to reject intakes

A. April 24, 2014 intake

We believe the information regarding the foster care child being forced to swallow or spit up and eat his vomit was sufficient for this child abuse report to have been accepted.

In order to accept a child abuse report, all that is required "is a child victim, a caretaker and an allegation that, if true, would result in founded abuse."[102] According to DHS's Employees' Manual guidance for "denial of critical care" allegations, there must be a reasonable belief of the following:

- A circumstance exists or has occurred which indicates a failure to provide food, shelter, clothing, medical or mental health treatment, supervision, or other care necessary to a child;
- The circumstance places a child's health and welfare at risk; and
- The circumstance has been caused as the result of acts or omissions of the person responsible for the child's care.[103]

The intake worker explained to Messersmith during the call why she believed the intake would ultimately be rejected:

> I will document it and staff it with my supervisor, I just don't know if it will rise to the level of child abuse, I mean if it would, it would because of what happened at the table, but I mean that's just gross, I don't know if it places him in any danger. If you can find out more about them being deprived food and they are losing weight, give us a call back, but it sounds like they are offering food and the kids just don't just like it, and maybe they need to make some adjustments to that, but that's something that Marcia and you can talk to the foster parents about, I don't know what it will rise to the level of abuse … I think it will be rejected and sent on to Marcia Hoffman.

Though the information was forwarded to the DHS ongoing-services worker, we do not believe this was sufficient. Instead, an allegation that a child is being forced to swallow, or spit up *and eat* his vomit should have warranted a child abuse investigation on its own.

It is also notable that this was the first child abuse report received in which an allegation was made that a child in the Ray home was forced to stand as punishment. The reporter in this call indicated that the 4-year-old child was made to stand in the corner "all day" after he had

[102] DHS's Employees' Manual, Title 17, Chapter A(1), Page 9, provides that a report must be accepted for an assessment when at least one of the following four factors is present: 1) The factors required for an allegation of the specific type of abuse are present; or 2) The child is receiving less than adequate care that endangers the child's life or health; or 3) There is insufficient information to determine whether this standard is met; or 4) Compelling circumstances are sufficient to infer that there is danger of the child suffering injury or death.
[103] DHS's Employees' Manual, Title 17, Chapter A(4), Topic 8, Page 1.

accidents in his pants. As we will cover in the sections to come, this is a concern that was repeatedly raised to DHS throughout several of the future child abuse reports.

B. May 7, 2014 intake

After Sabrina's death, DHS officials wrote in the Confidential Briefing that the May 7, 2014, intake would have been accepted today. When we sought further explanation, DHS told us that the decision to reject the intake was "in line with policy and practice at that time," but that more recently, "staff has been reminded to look for information that might appear to indicate things like manipulation with food, a child being singled out, bullied, extreme or unusual punishment, patterns emerging, similar reports from multiple reporters, etc."

Additionally, DHS clarified that intake workers have since been "retrained on acceptance criteria, with an emphasis on 'ruling in' rather than 'ruling out.' New instructions were provided to staff that for an allegation to be rejected, there must be sufficient information that abuse or neglect did not occur."

As such, DHS officials have determined that the decision to reject the May 7, 2014, intake was appropriate in 2014, but a reject decision would be inappropriate today. While we agree the intake meets today's criteria to be accepted, we disagree that the intake was appropriately rejected in 2014.

The developing patterns and the seriousness of the allegations at this time should have resulted in an accepted child abuse case. Although the reporter was referencing issues that had occurred to a former foster child nearly four years prior, the allegations were shocking and similar to the allegations made in recent reports.

The developing patterns and the seriousness of the allegations at this time should have resulted in an accepted child abuse case.

Additionally, we believe several aspects of the complaint, on their own, should have been sufficient to accept the child abuse report for "denial of critical care":

- Misty told [the child] that she needed to bite her sister, Misty told her that she had to bite her hard; in response Misty started laughing.
- Misty told [the child] to pick up a daycare child and [the child] couldn't hold her and dropped the baby; as a result, [the child] had to skip a snack.
- [The child] had to stand against a wall or over a vent all day as punishment; [The child] has a heart condition that causes her to have poor circulation, as well as curled toes, which would make it difficult and painful to stand for long periods of time.
- Punishment would cease when a DHS worker would come to the home, but would resume once the worker left.

C. November 25, 2014 intake

DHS officials asserted in their Confidential Briefing that the November 25 intake, when it was reported a daycare child was told to close her eyes when the Rays would strike one of Sabrina's sisters, would have also been accepted if it were made today.

We disagree that the intake was appropriately rejected even under the standards employed by DHS in 2014. Although the anonymous reporter had little direct knowledge of the physical abuse, we believe the information presented, coupled with her observation of the child's bruise and the report that the abuse had occurred on more than one occasion, warranted accepting the intake for a child abuse assessment for physical abuse.

During our interview, we listened to the audio recording of the intake call with the CSIU intake worker. He implied to the reporter that the intake would be accepted. The worker told us he believed he documented sufficient information for the intake to be accepted on the physical abuse allegation, and his preliminary decision was to accept.

He indicated his supervisor was out of the office that day and a different supervisor ultimately made the decision to reject the intake. The worker explained that back in 2014, it was sometimes difficult to work with other supervisors because their decision-making and expectations varied. For example, something that one supervisor may accept would not have been accepted by another supervisor. He stated that it used to upset him when another supervisor would reject an intake that he believed should have been accepted, though he never thought that he could question the supervisor's decision.

The intake worker explained, however, that the culture of the office has changed. Supervisors now maintain an open-door policy. He shared that the supervisors and CSIU staff are much more willing to meet to discuss decisions in greater detail. This change occurred, he said, in the last couple of years. He confirmed that DHS workers are now trained to "rule in" versus "rule out" when it comes to acceptance criteria.

The intake worker explained, however, that the culture of the office has changed. Supervisors now maintain an open-door policy.

We believe the information that was documented should have resulted in an accepted intake for physical abuse even under that standards employed in 2014. Further, this case was exacerbated by critical information that was not documented in the intake report that should have resulted in an accepted intake for "denial of critical care – failure to provide adequate food".[104] Specifically, the anonymous reporter said:

[104] DHS's Employees' Manual, Title 17, Chapter A(1), Page 9, provides that a for a situation to be assessed as "denial of critical care," there must be a reasonable belief of the following: (1) A circumstance exists or has occurred which indicates a failure to provide food, shelter, clothing, medical or mental health treatment, supervision, or other care necessary to a child and (2) The circumstance places a child's health and welfare at risk and (3) The circumstance has been caused as the result of acts or omissions of the person responsible for the child's care.

- And the girl [Sabrina's sister], I think she's about 13 or 14, but she's very, very, very thin, she's very small, she looks like she's about 8 or 9 years old. So I wonder if she's not eating right…

- I really feel that those children are just very afraid and they're being abused and they're being neglected. … I think that those children are very, very, very, very afraid of their parents – very afraid."

We asked the intake worker whether statements on the child's thin appearance and the children's fear of their parents should have been documented in the intake report. He replied yes. He explained that he did not include this information because he "honed in on" what he believed would be sufficient information for an accepted case – the information relating to the physical abuse allegation. Asked whether the statements should have prompted him to incorporate a "denial of critical care" allegation in his report, the worker agreed it should have. Nevertheless, he does not believe that the additional allegation would have been accepted for a child abuse assessment at that time because of the department's "rule out" criteria at the time.

Despite the intake worker's testimony, we believe all of the information provided by the reporter on the intake call clearly established a sufficient basis for accepting this intake on November 25, 2014.

Review of prior child abuse history

Intake workers are trained to retrieve and review various specified records – including previously rejected intakes involving the same child or family – from various computer systems and to use applicable information in determining whether to accept a report.[105] This process is referred to as "system checks" or "lookups." A system check may supply additional information to help ensure child and worker safety, if the intake is accepted for an assessment.[106]

Regarding child abuse records, DHS policy *requires* workers to "[r]etrieve, analyze, and assess the information contained in rejected intakes to determine whether or not previously rejected information, combined with the current allegation, meets the legal threshold for acceptance."[107] Intake workers are then expected to summarize any relevant prior history in the intake report.

Then-DHS Director Charles Palmer acknowledged this requirement following Natalie Finn's death: "Intake staff are to review the history of all assessments and intakes, rejected and accepted, when completing an intake."[108] During our investigation into the death of Natalie Finn, however, DHS officials acknowledged that their Employees' Manual does not explicitly state that intake workers are required to review all prior child abuse intakes and assessments (not just prior rejected intakes). The Employees' Manual also does not explicitly direct intake

[105] DHS's Employees' Manual, Title 17, Chapter A(1), Page 6.
[106] DHS's Employees' Manual, Title 17, Chapter A(3), Page 9.
[107] DHS's Employees' Manual, Title 17, Chapter A(1), Page 21.
[108] From then-DHS Director Charles Palmer's March 28, 2017, letter of response to a written inquiry from then-Senator Matt McCoy.

Clear patterns were developing … By May 7, 2014, DHS had received three food-related allegations, with prior reports having been made on September 20, 2013, and April 10, 2014.

workers to summarize any relevant prior history in the intake report.[109]

During our Finn investigation, we interviewed former DHS Administrator Wendy Rickman, who told us that reviewing previously rejected intakes allows intake workers to see whether there is a pattern of "numerous rejected intakes around the same topic."

Clear patterns were developing around the child abuse reports made about Marc and Misty Ray throughout 2013 and 2014. By May 7, 2014, DHS had received three food-related allegations, with prior reports having been made on September 20, 2013, and April 10, 2014.

The April 24 and May 7, 2014, child abuse reports – both of which were rejected – alleged the Rays made children under their care stand for long periods of time as punishment. DHS had received reports on October 25, 2010, and May 7, 2014, concerning the Rays providing inappropriate punishment tactics to the same child subject; specifically, locking the child in a closet when she defecated her pants.

DHS had received five child abuse reports about the Rays in 2014 with allegations related to food and physical abuse.

DHS had received five child abuse reports about the Rays in 2014 with allegations related to food and physical abuse. The commonalities were never discovered.

We did not interview the intake worker who fielded the May 7 abuse report regarding her handling of the call, or to ask whether she reviewed the Rays' prior history. However, we did interview this individual during our Finn investigation on her handling of a 2016 intake call related to a child abuse report. During that interview with us, she explained that "the decision to accept or reject was mostly based on what you heard in the phone call." The intake worker went on to report that, prior to a system upgrade that occurred after the Finn and Ray child abuse reports were received, it was "extremely cumbersome to go through 10 different cases" while working on an intake call.

Throughout our investigation into the death of Natalie Finn, we interviewed a number of intake workers at CSIU. There was an obvious, common theme shared by the workers – that they simply did not have time to consistently review child abuse histories when handling an intake call. We were told workers generally get 15 minutes between calls before they are placed back into rotation for new phone calls. Those 15 minutes offer the workers the opportunity to process the new intake and/or previous intakes, including reviews of prior child abuse history, before they are expected to take another call.

[109] June 4, 2019, letter of response by Deputy DHS Director Mikki Stier in response to an inquiry made in our investigation into the death of Natalie Finn. The letter also stated that a planned update to the Employees' Manual in fall 2019 will include the expectation to summarize any relevant prior history in the intake document.

However, since the Finn and Ray cases have come to pass, DHS has changed the protocol for how prior histories are reviewed by staff at CSIU.

In our view, this change – particularly the new expectation for supervisors to review the prior history for rejected intakes – is the most significant of DHS's intake - related improvements….

However, since the Finn and Ray cases, DHS has changed the protocol for how prior histories are reviewed by staff at CSIU. DHS's internal investigation concerning the death of Natalie Finn resulted in a change to have supervisors verbally staff all rejected intakes, and only a sample of the accepted intakes.[110] DHS noted that this change would free up time for the supervisors to review prior histories of proposed reject decisions. In our view, this change – particularly the new expectation for supervisors to review the prior history for rejected intakes – is the most significant of DHS's intake-related improvements since Natalie's and Sabrina's deaths.[111]

Based on the worker's prior testimony and the absence of historical information in the intake document, it does not appear that prior history was considered when deciding whether to reject the May 7, 2014, child abuse report concerning the former foster child in the Ray home.

We asked the intake worker who handled the November 25 intake if he recalled whether he had reviewed prior history – including rejected intakes and assessments – while he was processing his intake call. He replied that he believed he had. Asked why he did not document the information that he reviewed, the worker responded that he usually only documents prior history when he advocates for a decision to accept an intake, or if it is necessary to explain to field workers why it was accepted.

Though we do not have any information to dispute the intake worker's claim that he reviewed prior history, the intake document does not include any of the information that was reviewed, nor does it take note of any sort of pattern that was forming with food-related and physical abuse allegations. All of this information, had it been documented, would have supported a decision to accept the intake.

Forwarding information to the field worker

At the point that the April 24, 2014, intake was received, the child abuse assessment from the April 10 child abuse report was ongoing.[112] Yet, we found no indication that the information from the April 24 rejected intake was shared with, or referred to, the field worker handling the ongoing child abuse assessment. Similarly, we also found no reference that the May 7 intake information was shared with the field worker, whose assessment was closed that same day.

The April 10 report concerned Sabrina and her sisters while the April 24 report concerned a foster care child. Even though the child victims in the two child abuse reports were not the same,

[110] DHS's Executive Summary, Page 11.
[111] See https://www.legis.iowa.gov/docs/publications/CI/1130515.pdf.
[112] The April 10 child abuse assessment was closed on May 7, 2014.

to us it is clear that it was relevant information for the field worker to have in order to conduct a full and accurate assessment.

Daycare-licensing referrals

If a complaint of child abuse is received about a child-development home, DHS is required to conduct a home visit.[113] DHS's Employees' Manual states that intake staff are responsible for notifying licensing or child care registration staff when assessments have been initiated on a licensed foster family home, child care center, or registered child care setting.[114] The assessment worker is responsible for keeping licensing staff informed of progress and findings on the assessment.

Separately, the Employees' Manual directs that, "When it is alleged that child abuse has occurred in a child-development home, the protective service worker will immediately inform the child care registration worker."[115] The daycare licensing worker's role is to "focus on compliance issues with the child care law and the requirements for registration." When a daycare licensing worker is notified of child abuse allegations, it is considered a complaint against the daycare.[116]

Our interview with the DHS daycare licensing worker provided additional information on how the referral process works in practice:

> **Ombudsman**: Do you get complaints that you have to look into for every child abuse report that is made?
>
> **Daycare licensing worker**: They are supposed to contact us with that, we try to work together. Sometimes things do fall through the cracks. But we have the child abuse hotline of course, and we have a daycare complaint hotline, and they are usually communicating or sending stuff over to the other if there's concerns.
>
> **Ombudsman**: Is that for accepted intakes only, or rejected as well?
>
> **Daycare licensing worker**: Even if the intake is rejected, we still get the complaint. If it involves a daycare provider, we still have to address that.
>
> **Ombudsman**: Is that true even if it is a daycare provider say, but not a daycare child as the child victim?
>
> **Daycare licensing worker**: Yes, correct.

[113] IOWA ADMIN. CODE r. 441—110.12.
[114] DHS's Employees' Manual, Title 17, Chapter A(1), Page 19.
[115] DHS's Employees' Manual, Title 12, Chapter F, Page 64.
[116] *Id.*

According to records we received, it appears that the April 10, 2014, accepted intake was *the only instance* in which a referral was made to daycare licensing after DHS had received a child abuse report on the Ray family. A total of ten child abuse reports were filed against Marc and Misty Ray between August 2010 and November 2014.

According to the records we received, it appears that the April 10, 2014, accepted intake was *the only instance* in which a referral was made to daycare licensing after DHS had received a child abuse report on the Ray family.

We asked the intake worker about his handling of the November 2014 intake call:

> **Ombudsman**: Later on in the call, (the reporter) mentions that [the Rays] are child care providers, is this something relevant that should have been documented and referred to daycare licensing?
>
> **Intake worker**: Yeah, it definitely should have been documented.
>
> **Ombudsman**: What about a referral, is that something you guys typically do?
>
> **Intake worker**: We do. I don't know if we would have thought to do it in that situation. … They would take the information if we sent it to them, I just don't know that we would think to check the box to send it to them.[117]
>
> **Ombudsman**: But do you think it would have been a good idea with that statement [Sabrina and her sisters forced to do daycare work] alone?
>
> **Intake worker**: Definitely, it is something that should have been in there and done.

Additional communication failures

We found a number of issues relating to the July 5, 2014, child abuse assessment. As previously mentioned in this report, field workers are instructed to interview anyone who is familiar with the child and family who can provide additional pertinent information.[118] In this case, the reporter alleged physical abuse against a foster child, so we believe it would have been prudent to contact Messersmith, the FSRP worker, especially considering the identical allegations she had raised three weeks prior to the July 5 report. Messersmith reported to us – over five years

[117] In response to our inquiry about the protocol for daycare licensing referrals, DHS stated, "If the reported concern involves a child care provider and we confirm through system checks that the provider is either registered or non-registered, the intake worker marks a box in JARVIX labeled 'Referred to DHS Child Care Home Compliance.' Once the intake is completed and the supervisor has approved the intake, an email is immediately generated by the JARVIS system to the appropriate service area intake email box. Each service area has a person who is responsible for monitoring that inbox and forwarding the notification to the appropriate child care home compliance worker."
[118] DHS's Employees' Manual, Title 17, Chapter B(1), Page 32a.

after the incident – that she can still recall the bruising on the child's back and thigh, which she described as not common areas for bruises on children.

Messersmith reported to us – over five years after the incident – that she can still recall the bruising on the child's back and thigh, which she described as not common areas for bruises on children.

Based on the information we received from DHS and Hoffman, we do not believe that Hoffman informed the field workers of the contact from the biological mother's attorney that relayed Messersmith's allegations.

Equally concerning is the fact that Hoffman failed to share Misty's July 7 email. This was particularly important information considering that field workers had not observed any visible injuries on the child. Hoffman also failed to share the fact that the mother's attorney had emailed her with concerns about bruising on the child's back three weeks prior.

We believe a connection could have – and should have – been made that the bruising allegation from June 2014 was significant considering that Misty admitted to yellow skin discoloration and a bruise behind the child's knee on July 7. We pointed out to Hoffman that yellow skin discoloration could be a sign of a healing bruise from the June time period.

Hoffman's supervisor, Chappelle, also shared our position: "If there was bruising three weeks prior, it probably would have looked like that – that yellowish. Yeah, in hindsight I think it's relevant."

On the contrary, we believe the variance in stories underscored the need to share the information, particularly since information about the yellow skin discoloration came from the alleged perpetrator herself.

Chappelle stated that it would have been an expectation for Hoffman to visit the foster children after receiving such information. Based on our review of the records, Hoffman did not conduct any visits in July 2014.

Hoffman's excuse to us for not sharing this information with the field worker was because two people gave conflicting stories: Misty cited "yellow skin discoloration," but the field workers saw none. On the contrary, we believe the variance in stories underscored the need to share the information, particularly since information about the yellow skin discoloration came from the alleged perpetrator herself and was consistent with a recent report of bruising from the attorney.

Had information been shared appropriately between Hoffman and the field worker, we believe the physical abuse allegation could have been reviewed further, and ultimately could have changed the outcome of the investigation. This is significant because a child abuse report was received – and rejected – four months later regarding alleged physical abuse against one of Sabrina's sisters.

The allegations made in this report are very similar to prior allegations made in the October 15, 2010, accepted intake. In both reports, it was alleged that the Rays subjected foster care children to inappropriate punishments for having accidents in their pants.

In both reports, it was alleged that the Rays subjected foster care children to inappropriate punishments for having accidents in their pants.

Use of foster care "hold"

The response by the DHS foster care licensing unit on April 11 to initiate the "hold" on future foster care placements with the Rays was timely, as was the staffing with ongoing-services and the field worker and supervisor. We considered whether DHS made the appropriate decision to place the Rays' foster care license on "hold" rather than initiate a suspension or revocation. We detailed earlier in this report the conditions outlined in DHS policy for when a foster care license *must* be revoked, when it *may* be revoked, and when it may be suspended (See "Ray's Foster Care License," page 37). We did not find that the circumstances known at the time warranted a compulsory or discretionary revocation of the Rays' foster care license.

As far as suspending the license, one common condition that must be met for both the emergency and time-limited suspensions is that the health, safety, and welfare of any child placed in the home requires immediate action. While these conditions may not have been met when DHS discussed the hold on April 11, we believe they were clearly met later during the Millers' foster placement. Concerns were raised through a child abuse report on food-related issues, while another child abuse report raised physical abuse allegations. Additionally, throughout the duration of the placement, Messersmith continually raised issues regarding the Rays' ability to provide appropriate care for the children.

Given the limitations for revocation and suspension, it appeared the decision to place the Ray foster care on "hold" was reasonable. However, we could not find any DHS policy describing this practice. We asked DHS for clarification on its decision.

First, we asked whether placing the Rays on "hold" affected their license. DHS responded that "putting the foster home on hold meant that DHS would not place any additional children in the home until the issue has been resolved. The status of the license does not change."

We next questioned whether there was any specific policy that authorized placing a family on "hold." DHS shared that there is no policy that addresses putting a family on hold; rather, it was described as "an informal process."

The Rays continued to maintain a valid foster care license and daycare license throughout 2014 while additional child abuse reports were made and other concerns were raised.

The Rays continued to maintain a valid foster care license and daycare license throughout 2014 while additional child abuse reports were made and other concerns were raised. Of particular

concern was the decision to keep the Miller children in foster care with the Rays after a "hold" was placed, even while DHS received four child abuse reports during the 115-day period the children were in the home. Three of those reports pertained to foster care children; two of them specifically concerned the welfare of the Miller children.

Of particular concern was the decision to keep the Miller children in foster care with the Rays after a "hold was placed, even while DHS received four child abuse reports during the 115-day period the children were in the home.

The "hold" was never modified, and we received no records to suggest that DHS ever contemplated or attempted to formally suspend the Rays' foster care license.

In an interview with former DHS supervisor Mark Chappelle, we asked whether DHS may have thought that moving the Miller children to a different foster placement – essentially uprooting them – might cause more harm than good:

> Exactly, at least by our estimation. … **One of the things about the foster care system is that the kids always end up getting screwed. … the kid goes here, there, everywhere**. If we advocated for the kids to stay there, I think the logic would have been – I think we can protect these kids, I think we can keep a close eye on them – we don't want to disrupt those kids again. (Emphasis added.)

Nevertheless, DHS never made the determination that a suspension of the Rays' foster care license was warranted, and the Millers remained in the home.

Inadequate oversight by ongoing-services worker

We reviewed the DHS Employees' Manual, which details general provisions of providing social services, including certain goals that are required by Title XX of the federal Social Security Act.[119] One of the goals identified is: "Preventing or remedying neglect, abuse or exploitation of children and adults unable to protect their own interests; or preserving, rehabilitating, or reuniting families."

We considered whether DHS ongoing-services worker Hoffman achieved the goal of "preventing or remedying neglect" of the Miller children while she provided services to the family.

When a child is placed with a foster family, a foster family placement contract is executed between the foster parents and DHS.[120] A contract was executed between Hoffman and Misty Ray on the same day that the Miller children were placed with the Rays on April 4, 2014.[121]

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[119] IOWA ADMIN. CODE r. 441—130.7(1). "Services shall be directed toward the social services block grant goals of: a. Achieving or maintaining self-support to prevent, reduce or eliminate dependency. b. Achieving or maintaining self-sufficiency, including reduction or prevention of dependency. c. Preventing or remedying neglect, abuse or exploitation of children or adults unable to protect their own interest, or preserving, rehabilitating or reuniting families. d. Preventing or reducing inappropriate institutional care by providing or community-based care, home-based care, or other forms of less intensive care."

[120] DHS's Employees' Manual, Title 12, Chapter B, Page 135.

[121] DHS, *Foster Family Placement Contract*, 470-0716 (April 4, 2014).

Portions of the contract included the following considerations for the ongoing-services worker:

- "To make or arrange for monthly visits with the foster parents by either a Department social worker or a child welfare service provider to gather information about the care and supervision of the child."

- "To make or arrange for visits with the child by a Department social worker at least monthly. Refer to the case plan for specifics, as monthly visits is the minimum number for required visits."

We asked Hoffman whether the reference to the "Department social worker" in the contractual language referred to her. She replied that it did.

> … There is no information to suggest that Hoffman visited the children after the concern was raised that the youngest foster care sibling was bruised … the next visit did not occur until August 1, 2014.

In regards to the requirement that a DHS social worker arrange for visits with the child at least monthly, Hoffman told us she believed she had fulfilled that obligation. However, according to the documentation we received from DHS, there is no information to suggest that Hoffman visited the children after the concern was raised that the youngest Miller sibling was bruised. As previously mentioned, Hoffman's case notes document a visit on June 4, 2014; the next visit did not occur until August 1, 2014, four days after the children had left the Ray home and were returned to their mother.

Thus, we found no information to suggest that Hoffman conducted a visit in July 2014. The Miller children were in foster placement until July 28, 2014. July 2014 was also a critical month considering that a child abuse report was made on July 5 concerning the youngest sibling.

Relevant portions of the foster family placement contract included the following requirements for the foster parents:

- "To accept the child for foster care placement and to provide care for the child to include, but not limited to: food, housing, clothing, recreational activities, personal care items, and any additional needs defined in the case plan."

- "To cooperate with the Department and Juvenile Court Services in all matters concerning the case plan for the child and the child's family and make no independent agreements with the child's parents or guardians without consulting the child's social worker or juvenile court officer."

Throughout the nearly four months that the Miller children were placed with the Rays, a total of four child abuse reports were made against Marc and Misty – two concerning the Miller children. Each of the reports called into question whether the Rays were upholding their part of the foster parent contract and their ability to provide a safe home for the foster children.

Because all of these reports made allegations concerning the safety and well-being of children in

the Ray home, we asked Hoffman whether she was familiar with the child abuse reports received by DHS during the Miller's placement with the Rays. Hoffman stated that she recalled there being a concern; however, she "never saw any reports." She said it was not her common practice to review child abuse intakes or any subsequent assessments concerning foster parents, even if the allegations were about foster children on her caseload.

Asked why, Hoffman replied that there was a "sense of security" with the family: "They were a registered daycare, and I saw the children, or the people coming to get their children, that was a sense of security. Because there were people coming and going, and it was set up like a daycare, so that is a sense of security right there, yeah."

There was a sense of security with the family: They were a registered daycare, and I saw the children, or the people coming to get their children.

Field workers handling the child abuse assessments, however, were relying on Hoffman's opinion of the family in their investigations. During the April 10, 2014, assessment, a field worker consulted Hoffman on her interactions with the family. Hoffman reported that she had made unannounced visits to the home and had never seen any withholding of food or maltreatment of the children. But in Hoffman's testimony to us, she suggested that her visits were actually *announced.*

We asked whether she believed this was appropriate, especially considering the number of concerns raised about the Ray family. Hoffman responded that the "majority of the visits have to be announced so you can get the job done." Hoffman stated that she recalled the Rays were being cooperative with her visits and always allowed her in the home.

Whenever a DHS worker would come, the punishment would stop, and it would resume when the worker left.

One of the allegations in the May 7, 2014, rejected intake was that "whenever a DHS worker would come, the punishment would stop until he left and it would resume when this worker left." This is extremely concerning. We believe Hoffman's assertion that she was making *unannounced* visits to the home likely gave a false impression to field workers.

In an interview with Hoffman's supervisor, Mark Chappelle, we questioned which was the better practice: unannounced visits or announced visits. Chappelle reported that unannounced visited were preferable without question. However, he pointed out that unannounced visits can pose a special challenge. He asked:

> How much time can you spend running around the (Dallas County) countryside trying to find families who aren't there? Do I think it's okay? Not so much … But can you afford to? We had an expectation to see 100% of families every single month, how are you going to do that with 50 families, and you have 20

We had an expectation to see 100% of families every single month, how are you going to do that with 50 families, and you have 20 working days?

working days? That was part of my concern for my folks.

We believe it is noteworthy that Marc and Misty operated an in-home daycare, and neither parent worked outside of the home. This meant DHS workers could easily have visited the home unannounced with reasonable expectations that one or both would be home.

We found shortcomings in Hoffman's oversight of the Ray family occurring as early as May 2014, following the staffing between foster care licensing and ongoing services. The foster care licensing worker, notified his supervisors of the issues the same day he received the child abuse report, and the supervisors got SWA McInroy involved immediately. It was then determined that the current foster care children (the Millers) would be questioned about the allegations, and assessed to ensure they were safe.

All of these preliminary steps were appropriate, especially considering there had already been a food-related child abuse report concerning one of the foster care children. However, when it came to actually executing the plan established by foster care licensing staff and McInroy, ongoing-services staff, particularly Hoffman, fell short. Although Chappelle laid out the allegations of the May 7, 2014, rejected intake to Hoffman in an email, she never asked the children about the specific issues, and thus did not fulfill the specific requests made by McInroy. Instead, she stated that she "took care" of the children by checking in on two of the three.

DHS policy provides that one of the objectives in placing a child in foster care is to protect the child and provide care in a nurturing and stimulating environment on a temporary basis.[122] Frankly, we believe DHS failed to achieve these objectives for the Miller children while they were placed in foster care with the Rays.

FSRP services and interference with child abuse report

Messersmith was the FSRP worker for several foster care children placed in the Ray home. She believed that throughout her one-year employment with Mid-Iowa, she had at least one child on her caseload who was involved with the Rays at any given time, whether through protective daycare or foster care.[123] She said that she always thought something was "off" with the Rays. She felt she was alone in this respect, however. Messersmith reported that "everyone" praised the Rays and talked about how great they were. Asked who "everyone" referred to, Messersmith replied that staff at both DHS and Mid-Iowa only had positive things to say about the Rays.

Messersmith reported that "everyone" praised the Rays and talked about how great they were.

[122] DHS's Employees' Manual, Title 12, Chapter B, Page 1.

[123] In addition to the report she made on April 24, 2014, Messersmith has been referenced previously in this report as it relates to the two abuse reports she made concerning another foster care child placed with the Rays: September 13, 2013 (rejected) and September 20, 2013 (accepted).

Messersmith informed us that DHS and Mid-Iowa employees took their own children to the Rays' daycare. She felt this created a sense of security around the family – a preconceived notion that because the employees' children were fine at the daycare, all other children in the home would be fine as well. Messersmith reported to us that she felt she was treated as an outsider, questioning one of the community's "treasures." She recalled the feeling she received from others was: "Who is this girl to come into our community where she doesn't know anybody and make this judgment over these amazing people?"

Messersmith informed us that DHS and Mid-Iowa employees who took their own children to the Rays' daycare.

This sentiment came from a specific conversation that Messersmith had with a DHS employee, who Messersmith recalled was Facebook friends with the Rays. When Messersmith raised concerns, this DHS employee responded, "Shelby, do you even know who you are talking about? I took my kids there for years, and they were fine."

Chappelle confirmed that Marc and Misty had advocates within DHS. Considering that there were DHS and Mid-Iowa workers who had children in the Rays' daycare, their mentality was that "someone is watching out for their kids [so they] just didn't want to admit there could be something wrong there."

Chappelle also acknowledged the potential for a conflict for DHS workers whose own children were placed in a daycare overseen by the agency. "You never know what is going to happen in those daycare or foster care homes, and if something does come up, then you're a DHS worker – what are you going to do?" he asked. "Are you going to support the home or are you going to support the department for whom you work? Even if nothing happens, I think it's dangerous to do that."

While many felt a sense of security with the Rays, Messersmith recalled that there was also a *need* in the community to keep the daycare and foster care placement option open. She pointed out that there was nowhere else for many of these children to go. Messersmith speculated that it was easier for everybody to keep sending children to the Rays because it would be much harder to find a different place for them to go.

Messersmith speculated that it was easier for everybody to keep sending children to the Rays because it would be much harder to find a different place for them to go.

This sentiment was also shared by Chappelle, who told us, "It was always hard to find a foster placement, particularly if you had three kids, or kids with special needs." When asked if this was especially the case in Dallas County, Chappelle noted that there were not a lot of options in the area, so the choice was to place the children in the few available homes – including the Ray home – or send them out of the county.

Some of the issues that Messersmith reported to DHS were concerns that came directly from a child victim. Additionally, Messersmith recalled vivid details provided to her by a former foster child in the Ray home concerning the treatment of Sabrina and her sisters. Messersmith reported

the information to DHS on September 20, 2013, and it was accepted for an assessment; however, she does not believe that she was ever contacted by the field worker.

Messersmith stated that she recalled a lot of food and eating-related issues with the children in the Ray home, which raised red flags to her. She said that it was difficult to advocate and get help for these children because her concerns were not taken seriously by DHS and her supervisor, Susan Smalley.

In fact, it was not just Messersmith who learned of food-related issues with the foster care children. Documentation from Mid-Iowa shows that Smalley covered a FSRP visit for Messersmith on May 7, 2014, and learned from one of the Miller children's' teachers that the child had an increased appetite "since being at the foster home." Smalley encouraged the teacher to contact the Rays about this. This is the same allegation made during the April 24, 2014, rejected intake by Messersmith. Documentation shows that Messersmith notified Smalley of the report by email the same day the intake call was made, meaning Smalley would have already been aware with the issue.

Within Mid-Iowa, Messersmith told us that she received constant "pushback" from Smalley about the Rays' treatment of the adopted children and foster care children. "It was very repetitive." However, the resistance only applied to the Rays, not any other family in her caseload.

Messersmith told us that she received constant "pushback" from Smalley about the Rays' treatment of the adopted children and foster care children.

Asked for clarification on the resistance that she received, Messersmith stated that Mid-Iowa workers were directed to discuss concerns with their supervisor before making a child abuse report.

> **Ombudsman**: Did you have to request permission or approval from your supervisor before you made a child abuse report to DHS?
>
> **Messersmith**: Yes, this was a Mid-Iowa rule, they want you to correspond with your supervisor, to make sure the case is understood and worthy of reporting.

Messersmith recalled thinking this was an odd rule – one that she had never been subject to with other employers as a mandatory reporter.

We interviewed Smalley, currently the director of FSRP services at Mid-Iowa, about the practice of FSRP workers obtaining permission before reporting suspected child abuse to DHS. Smalley commented, "That is our practice, to make sure staff are being in touch with their supervisors to discuss the situation – so we are aware – supervisors need to be aware what is going on with the family."

We inquired whether the practice is for purposes of *awareness* or *approval*. Smalley responded, "I think it's a discussion based on the information that our staff have, and together making sure they are following the guidelines – as a mandatory reporter, does it meet those expectations to be considered suspected child abuse."

Our interview with Smalley included the following exchange:

> **Ombudsman**: Did you ever advise Shelby that it would not be a good idea to submit a report to DHS?
>
> **Smalley**: No.
>
> **Ombudsman**: Did you ever advise Shelby that you did not think certain action warranted a report?
>
> **Smalley**: There were concerns that were clearly documented that Shelby had, but if the information was not first-hand reported to Shelby, as a mandatory reporter, she cannot – that is not first-hand knowledge, that is not something she observed or was reported to her… therefore it does not constitute making a report of child abuse.
>
> **Ombudsman**: Is this a specific instance?
>
> **Smalley**: No, I don't recall specifically doing that.
>
> . . .
>
> **Ombudsman**: If Mid-Iowa or a supervisor tried to dissuade a worker from making a report, do you believe they could do so under the law?
>
> **Smalley**: As a mandatory reporter, our staff, if they feel it meets criteria to make a report, they have the ability to do that, if it met those criteria, I would not dissuade a staff to not make a report of suspected child abuse.

We asked Smalley whether she believes that – looking at the information today – the bruising concern identified in the FSRP report should have been reported to DHS.

> **Ombudsman**: Based on the information contained in the FSRP report, do you believe the bruises should have been reported to DHS?
>
> **Smalley**: I would say bruises alone and on their own, are not reportable. It is the manner in which it is communicated as to how those bruises may have occurred – that is what could be potentially reportable.
>
> **Ombudsman**: Would placement [of the bruising] be a factor?
>
> **Smalley**: Placement … it could be.

Messersmith indicated that the bruises were not in "play areas" and appeared to be non-accidental injuries that she believed were caused by the Rays. In our judgment, the information concerning the bruises – particularly the placement of the bruises – support the assertion that a child abuse report should have been made.

In our judgment, the information concerning the bruises – particularly the placement of the bruises – support the assertion that a child abuse report should have been made.

Smalley told us that she did not recall discussing the bruising issue with Messersmith in June 2014, nor did she recall how she responded.

When we interviewed Hoffman, we asked her, in general, whether there was frustration with Messersmith making reports and raising concerns about the Ray family. Hoffman responded that, "because there was just – nothing could ever be proven, and it was looked into. **So, if you keep making reports but nothing can ever be proven, that doesn't help anybody in that case**. … everything was looked into and was never founded." (Emphasis added.)

Separately, we asked Smalley to elaborate on her June 18 email to Mid-Iowa's Lori Mozena, in which she discussed a meeting she had with Messersmith and Mark Chappelle. In the email, she wrote that Chappelle agreed that a "public flogging" was not necessary but that Messersmith needed to "hear from the DHS end." Smalley stated that the meeting was called because DHS believed Messersmith had gone to a mother's attorney to report information and concerns, rather than bringing them to DHS's attention. She explained that Chappelle wanted to have a conversation about the issue and "make an example" of Messersmith's mistakes in a training setting. However, it was ultimately determined that Chappelle, Smalley, and Messersmith would meet to discuss Messersmith's handling of the case.

Asked for his comment on Smalley's statements, Chappelle stated that he did not recall wanting to make an example of Messersmith's actions during a training.

> I would like to think I wouldn't be a jerk to call someone out like that in an embarrassing way. If I had Susan and Shelby in front of me and I knew Shelby was talking to an attorney, I would say that she can't do that. But crucifying her as an example to others, no, that's not how I operate.

Although Chappelle does not recall intending a "public flogging" of Messersmith, we believe that the evidence suggests a clear intention to reprimand Messersmith for speaking up. The outcome of the meeting was essentially a *private* flogging, in which Messersmith left feeling defeated after receiving a clear message – "do your visits and shut up."

Although Chapelle does not recall intending a "public flogging" … the evidence suggests a clear intention to reprimand Messersmith for speaking up.

During his interview with us, we asked Chappelle to elaborate on his concerns. He explained

that there is "a whole lot of confidentiality and ethical issues with this." Chappelle shared that "if Shelby felt she wasn't being listened to, and felt like she needed to cause something to happen, I kind of understand that logic, but no, you just cannot do that."

While we understand that DHS has contracted with Mid-Iowa to provide the FSRP services on their behalf, we do not believe that this would preclude the FSRP worker from sharing concerns with an interested party in the case, such as the mother's attorney. There are definite examples of confidential information that should not be shared – such as information that Messersmith learned only through her access to, or discussions with, case management or the ongoing-services worker. However, potential abuse that Messersmith witnessed herself that she found concerning does not fall under this confidential category.

We agree with Chappelle that an FSRP worker should not raise concerns with a parent's attorney "rather than going to DHS." However, it is evident that Messersmith had repeatedly brought her concerns to DHS, and those concerns were ignored to an alarming extent. Disclosing what she knew to the mother's attorney may have represented some kind of violation of etiquette from Chappelle's perspective, but we believe that Messersmith was acting in good faith to ensure the safety of the children. In hindsight, it may have been preferable for Messersmith to express her concerns to the attorney more openly and transparently – for example, in an email that included Chappelle, Hoffman, and the other legal parties to the case.

Messersmith explained to us that her job as an FSRP worker was to advocate for families in the DHS system and provide help for the children and parties involved.

We find, however, that Hoffman failed to take Messersmith's concerns seriously. Messersmith's documentation from 2014, as well as her testimony to us, illustrated her grave concerns for the safety and well-being of the Ray children and the foster children in the home. Messersmith informed DHS of these concerns, but believed her efforts were being disregarded. Hoffman's recollection of her response to Messersmith's concerns – that there was no benefit to keep reporting concerns when nothing could be proven – supports Messersmith's claim that she had received resistance on the issues she had raised.

> We believe Messersmith showed courage and integrity at a critical moment when she knew the children were being mistreated and that DHS was failing them.

We believe Messersmith showed courage and integrity at a critical moment when she knew the children were being mistreated and that DHS was failing them. Unfortunately, DHS and Messersmith's supervisor focused their attention on correcting her breach of etiquette rather than acting on the serious and urgent concerns she had identified. It would be disappointing and unfortunate if Chappelle, Hoffman, and Smalley had *merely* disregarded Messersmith's warnings. But it is appalling and shameful that Chappelle and Smalley were actively stifling her efforts and reprimanding her for speaking up.

CONCLUSIONS AND RECOMMENDATIONS

Many significant events occurred between April and November 2014. During that seven-month

period, DHS was actively involved with the family through the receipt of five child abuse reports (two accepted intakes and three rejected intakes), a daycare licensing complaint, foster care licensing and ongoing-services, and FSRP services.

Keeping foster children in the home

Regarding the decision to place a "hold" on the foster care license, we conclude that the initial decision following the April 10, 2014, accepted intake was appropriate. We do question, however, DHS's decision to keep the Miller children in the Ray home after it had received three additional child abuse reports about the Rays, two of which involved the Miller children.

What is equally troubling is allowing children to be placed in a foster home in which there is a continual concern for the well-being of the children.

We concede that placing children in foster care creates a disruption in their lives. By itself, changing placements – especially if they are moved outside of a familiar community – could be exceptionally stressful.

What is equally troubling is allowing children to be placed in a foster home in which there is a continual concern for the well-being of the children. We believe that the risk in the Ray home was too high.

There is no formal policy regarding the practice of placing a foster care family on "hold." Additionally, there is no articulated procedure concerning if and when foster care children should be removed while there is a hold in place. In this instance, DHS determined on April 11, 2014, that a "hold" would be placed for *future* placements, but the Miller children would remain with the Rays.

We believe DHS would benefit greatly by creating a policy that details the protocol for placing a foster family on "hold." Further, the protocol for handling the children currently placed in the home should be examined. In this case, DHS debated at an April 11, 2014, staffing whether the Miller children should be removed from the Rays' home. We do not believe the question should have been *if* the children should be removed, but *when*. If DHS does not trust the foster home for future placements, there should be no question whether the foster home should be trusted for current placements. Logistically, we understand that it may have taken time to identify a new placement for the children, and removal may not have happened immediately. However, there is no question that as soon as the decision was made to place the home on "hold," DHS should have promptly begun the process to consider alternative placement options. Keeping the children in the home should never have been an option.

We do not believe the question should have been *if* the children should be removed, but *when*.

We found the decision to keep the Millers in the Ray home following the "hold" was unacceptable, and the decision to keep the Millers in the Ray home as new concerns and child abuse reports continued to be filed was unfathomable.

As detailed in our analysis, we did not find there was a basis to revoke the Rays' foster care license. However, we believe sufficient grounds existed at least later in 2014 to formally suspend their license.

We do not believe any person has a *right* to hold a foster care license. DHS is granted the authority to dictate who should have a foster care license, and who should not. If events occur to put into question whether foster parents can appropriately care for foster children, or whether the children placed in the home are safe, then DHS should have the ability to suspend the foster care license and remove any children currently placed in the home. Given existing policies, however, it appears that the conditions for suspension are much too difficult to achieve, and unfortunately – as was the case with the Millers – foster care children are the ones who ultimately suffer. DHS should review the standards to suspend a foster care license, such that the focus is on the best interest of the children.

DHS should review the standards to suspend a foster care license, such that the focus is on the best interest of the children.

Decision to reject intakes

It is our opinion that the April 24, 2014, intake should not have been rejected. In addition, we do not agree with DHS's determination following Sabrina's death that the May 7 and November 25, 2014, intakes were appropriately rejected at that time.

Notifications to daycare licensing

We conclude that daycare licensing staff did not receive notice of *any* child abuse report made to DHS involving the Rays, with the exception of the April 10, 2014, accepted intake.

Failures by the ongoing-services worker

We found no supporting documentation that Hoffman visited the Rays in July 2014. During that same time, the Rays had refused Messersmith entry into their home. According to DHS records, it appears that a number of the visits occurred at the biological mother's residence, and not at the Ray home, as required under the foster family placement contract.[124]

We also found that Hoffman failed to review the intakes and assessments that occurred during the placement of the foster care children under her watch, which prevented her from ensuring the safety of the foster care children. Hoffman's reliance on other DHS employees having oversight of the Rays was misplaced. Hoffman failed to understand that the majority of the others involved with the family were counting on *her* to have eyes and ears on the family.

Hoffman failed to understand that the majority of the others involved with the family were counting on her to have eyes and ears on the family.

[124] Case notes authored by Hoffman detail visits on June 4, and August 1, 2014, to the Miller home. According to the case notes, visits to the Ray home occurred on April 4, and May 6, 2014.

DHS administration and foster care licensing took affirmative steps to formulate a plan following the rejected May 7, 2014, intake call about a former foster care child. That placed the responsibility on Hoffman to question the current foster children on the specific allegations and to ensure their safety. We found this plan was sound, but unfortunately, it was not carried out appropriately by Hoffman when she failed to ask the children specific questions relating to the rejected intake or contact the service providers.

Additionally, Hoffman shared with us that she cannot recall seeing the adopted children beyond perhaps on one occasion, when she was introduced to one of the adopted daughters. This means that Hoffman's report that she had never seen any withholding of food or maltreatment of Sabrina or her sisters was misleading.

Regarding the July 5, 2014, accepted intake and unfounded assessment, we conclude that Hoffman failed to provide important information to the field worker handling the assessment. We believe this failure significantly impacted the field worker's investigation.

Failures of ongoing-services worker's supervisor

We have concerns about Chappelle's actions – and inactions – in this case. First, we question Chappelle's rationale for keeping the Miller children in the Ray home when the "hold" was placed following the April 10, 2014, accepted intake and staffing. Chappelle explained to us that DHS had intended to keep an eye on the children to ensure their safety in the home. However, this rationale seems seriously flawed. DHS did not believe other children should be placed in the home, but the Miller children could remain. In essence, DHS decided other children could not be safe in the home, but the Millers were treated as an exception. Based on the events that followed, the Millers were just as vulnerable as any prospective foster child.

> DHS decided other children could not be safe in the home, but the Millers were treated as an exception.

Additionally, as Hoffman's supervisor, Chappelle was in charge of ensuring Hoffman was handling her cases appropriately and in compliance with DHS policies and practices. What we learned, however, was that Chappelle was initially unaware that Hoffman had not fulfilled the requests handed down by DHS administration following the May 7, 2014, rejected intake and staffing.

Interference with making a child abuse report

Iowa Code section 232.70 states: "The employer or supervisor of a person who is mandatory or permissive reporter shall not apply a policy, work rule, or other requirement that interferes with the person making a report of child abuse."[125] If it results in a report being suppressed, we firmly believe that Mid-Iowa's practice of requiring FSRP workers to confer with a supervisor prior to making a child abuse report is a violation of law.

> If it results in a report being suppressed, we firmly believe that Mid-Iowa's practice of requiring FSRP workers to confer with a supervisor prior to making a child-abuse report violates the law.

Messersmith should have been permitted to make the child abuse report concerning the bruising on the foster care child that she observed during her visit on June 12, 2014. Though Smalley does not recall whether Messersmith raised concerns of the bruising to her, we found there was sufficient corroborating evidence to suggest that this discussion did occur and resulted in the decision that Messersmith would not make a report to DHS. Hoffman's documentation in her case notes specifically supports this finding.

We believe there was sufficient information to warrant a report to DHS based on the observations made by Messersmith during her visit. DHS policy indicates that for a report to constitute an allegation of physical abuse, there must be "damage to any bodily tissue that would require a healing process or there is damage to the body that results in the death of a child."[126] An accepted intake will lead to a child abuse assessment when it involves any non-accidental physical injury, or an injury that does not match the history given for it, that is suffered by a child as a result of the acts or omissions of a person responsible for the care of the child.[127]

We also believe that some of the pushback from Smalley could have stemmed from Chappelle's concerns about Messersmith's handling of the FSRP case with the Millers. Smalley recalled Chapelle raising the issue about Messersmith going around DHS to the mother's attorney; this could have caused Smalley to impose a tighter rein on Messersmith's handling of the case.

Despite the resistance from Smalley, Messersmith stated that the CEO of Mid-Iowa[128] met with her and was supportive of her handling of the case.

The Ombudsman recommends that DHS:

2. **Create a policy to articulate the protocol for placing a foster family on "hold," and ensure that foster care children placed with a family on "hold" status are removed as soon as possible.**

[125] IOWA CODE § 232.70(2).
[126] DHS's Employees' Manual, Title 17, Chapter A, Page 6
[127] IOWA CODE § 232.71B(1)(a)(1).
[128] The website for Mid-Iowa identifies Christine Secrist as the founder and CEO.

3. **Review the standards necessary to suspend a foster care license, such that the focus is placed on the best interest of the children placed in the home and whether those children are in a safe place.**

The Ombudsman recommends that Mid-Iowa:

1. **Review its practice and policy that requires consultation between FSRP services workers and supervisors to ensure non-interference with reporting requirements, consistent with Iowa Code section 232.70.**

2015 Family Assessment

Following the November 25, 2014, rejected intake, nearly a full year passed before there was another child abuse report concerning the Rays.

NOVEMBER 2, 2015 ACCEPTED INTAKE AND FAMILY ASSESSMENT

DHS received a child abuse report on November 2, 2015, regarding concerns about Sabrina and her sisters. The call was made during business hours and handled by a Centralized Services Intake Unit (CSIU) worker.

A store customer had seen the Ray family, including the three girls, at Wal-Mart on November 1. The customer had concerns about the children due to their appearance, so she followed the family out of the store and wrote down the Rays' license plate number.

The customer reported to DHS that the children appeared "listless and ill," and two of the children looked emaciated. She described that one child who appeared to be 12 years old "was complete skin and bones" and "looked anorexic." The reporter explained that the three children were not behaving normally.

> The customer reported that the children … appeared "listless and ill," and two of the children looked emaciated.

The intake was accepted for a family assessment and assigned to the field worker who had previously completed the April 10, 2014, assessment involving the Rays. The field worker conducted an unannounced home visit on the same day the report was made. She spoke to Sabrina and her sisters away from Marc and Misty. The girls said that they were fed regularly and ate as much as everyone else in the home.

The worker documented her visit in the family assessment summary. She wrote that Sabrina "is very thin" and added, "but has always been very thin." It was noted that Sabrina "eats as much as she wants, both snacks and three meals a day, but has a very high metabolism." When we asked the field worker where she got this information, she stated that it came from Sabrina herself.

The child protective services family assessment summary also noted that "Sabrina [and her sisters] were home schooled, which was overseen by the Home School Department of the Perry School system."[129]

After the home visit, the worker contacted the children's medical provider for records. She documented that she was told the children were seen on an as-needed basis for illnesses and

[129] Telephone call with Department of Education School Improvement Consultant and Home School Contact Buffy Campbell on March 2, 2020. It appears the information given to the field worker was that the girls were completing a Home School Assistance Program (HSAP), which is a program in which a district must employ one or more properly licensed instructors to provide instruction and have contact with the family at least four times per quarter. However, it was explained by the Department of Education staff that the Perry School District does not have a HSAP.

checkups. DHS later revealed in the Confidential Briefing that, aside from a Wal-Mart eye exam in 2014, their records reflected that Sabrina had not been seen by a medical provider since July 2012.[130]

The field worker and her supervisor determined that the children were safe, and no referrals were made to community care. No formal finding was made by the field worker, as a family assessment does not include a determination of whether abuse occurred.[131] The family assessment was closed on November 12.

ANALYSIS

We do not have any concerns about the manner in which the CSIU intake worker handled the call, or the intake unit's decision to accept the report as a family assessment. The allegation was "denial of critical care" and the children were not determined to be in immediate danger.[132] The intake worker appears to have appropriately reviewed and documented the prior history of the family; "History in JARVIS indicates previous concerns about the adults not feeding the adopted children."

We did, however, consider whether the field worker should have taken further action before concluding that there was no concern with Sabrina's weight. The DHS Employees' Manual provides that "the child protection worker shall contact a medical or mental health professional when advice is required in order to determine if the child requires or should have required medical or mental health care as the result of abuse."[133] Additionally, DHS may refer a child to a physician for a physical examination if warranted by the circumstances.[134]

When asked why she did not refer the children to a physician or seek medical consultation, the worker replied that she did not think it was necessary because she had contacted the children's medical provider and did not see, in her opinion, any signs of malnourishment such as sunken cheekbones and or bones "sticking out." Further, she explained that "the children didn't seem to be any thinner than the last time" she saw them. The worker's previous assessment with the Rays (stemming from the April 10, 2014, child abuse report) included an allegation that the Rays were not feeding the adopted girls. She had documented in that assessment summary that the children told her that they were given three meals and two snacks each day, and were never denied food.

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[130] After Sabrina's death, Misty told law enforcement officials that Sabrina had last been seen by a medical provider "two or three years ago" (which would have been 2014 or 2015), but Misty indicated that she could not recall which doctor they had seen.

[131] IOWA CODE § 232.68(5)(c).

[132] There are two types of assessments: a child abuse assessment and a family assessment. The family assessment is not used in physical or sexual abuse cases, or other types of serious abuse cases. The intent of the family assessment is to match families with services and supports. A field worker must begin a family assessment within 72 hours of receiving the report. See May 1, 2015, presentation, titled "Differential Response," by Julie Allison, then-Bureau Chief for DHS's Bureau of Child Welfare and Community Services and "Iowa Child Welfare Assessments by Disposition, County and Year" at https://data.iowa.gov/Public-Safety/Iowa-Child-Welfare-Assessments-by-Disposition-Coun/er5e-kmgq.

[133] DHS's Employees' Manual, Title 17, Chapter B, Page 8a.

[134] DHS's Employees' Manual, Title 17, Chapter B, Page 9.

Additionally, we asked for clarification on the information that the field worker received from the children's medical records request. She stated that she placed a call to the children's medical provider during the assessment but did not receive a call back until after the family assessment was closed. The information received, she explained, did not change the outcome of the family assessment that the children were deemed safe. Had there been concerns raised after her review of the medical records, the worker said that she would have either requested additional time for the family assessment, or requested that it be transferred to a child abuse assessment pathway.[135]

Asked why she closed the family assessment *before* receiving the medical information, she stated that generally it can take a few days to get medical records, and since field workers get only 10 days to complete the family assessment, they typically do not have sufficient time to obtain a response from the medical provider. In this case, because no other concerns were brought up when the worker visited the Ray family, she determined that it could be closed without first receiving and reviewing the medical information.

We asked the field worker if she received adequate training through DHS on determining whether a child is malnourished. She replied that she did not. Specifically, she indicated that she had not received *any* training on how to identify malnourishment. She believed field workers should receive specialized training concerning malnourishment, though she acknowledged that workers have been told to be more cognizant of food-related allegations following the deaths of Natalie Finn and Sabrina Ray, and to specifically ask questions relating to what the children are eating in the home.

We asked the field worker if she received adequate training through DHS on determining whether a child is malnourished. She replied no … she had not received *any* training.

CONCLUSIONS AND RECOMMENDATIONS

At the time the November 2, 2015, intake report was received, there had been three prior food-related reports made about the Rays. Although we did not find any major concerns regarding the handling of the family assessment – an unannounced visit was made, the children were interviewed alone and were asked about the allegations – it is notable that this same approach was taken in prior assessments concerning similar allegations, and the same conclusion was reached. It begs the question – why were reports continuing to be made even after the issues were assessed?

Additionally, this family assessment was the last opportunity DHS had to interview and observe Sabrina and her siblings, and the last time DHS had eyes and ears on Sabrina prior to her death.

This means that the last individual charged with assessing the safety of Sabrina, the field worker, did not have adequate training – or indeed *any* training – on identifying malnourishment in children.

[135] A family assessment is reassigned to a child abuse assessment any time it appears the child is not safe. See May 1, 2015, presentation, titled "Differential Response," by Julie Allison, then-Bureau Chief for DHS's Bureau of Child Welfare and Community Services and "Iowa Child Welfare Assessments by Disposition, County and Year" at https://data.iowa.gov/Public-Safety/Iowa-Child-Welfare-Assessments-by-Disposition-Coun/er5e-kmgq.

At the time of her adoption by the Rays in 2012, Sabrina weighed 57 pounds; six months later she weighed 53.8 pounds. One and a half years after her adoption, a field worker described Sabrina as "thin but not abnormally thin" in a September 20, 2013, assessment. Seven months later, on April 10, 2014, a report was submitted alleging the Rays did not feed the adopted girls. Another report was filed later that year, on November 25 that alleged one of the Ray children was "very, very, very, thin," and suggested she was not eating right. This all came before the last report on the family in 2015 that the children looked emaciated.

The pattern that developed throughout the years and months prior to this family assessment is evident.

In both the Finn and Ray cases, the children were coached to provide certain answers to DHS questions. In addition, the parents in both cases were adept at explaining away allegations. Similarly, in both cases, the field worker failed to confirm malnutrition upon visual inspection. Had the field worker been trained to identify malnutrition rather than trust the explanation she received, the outcome may have been different.

In both the Finn and Ray cases, the children were coached into providing certain answers to DHS questions … Similarly, in both cases, the field worker failed to confirm malnutrition upon visual inspection.

In addition, DHS field workers would benefit greatly if they had medical professionals they could consult on such cases. Sabrina's medical records, when viewed in the context of the repeat reports about her thin appearance, could have triggered a medical provider to look more closely at the situation.

One option DHS should consider is implementing a medical-related assistance service similar to the Service Help Desk that provides explanations and answers to DHS staff throughout the state. An assistance service, staffed fulltime by medical professionals, could operate as a resource for DHS workers who have questions regarding a medical-related issue both when conducting child abuse assessments and when developing safety plans.

Another option is for DHS to develop a contractual relationship with Iowa's county public health agencies as they employ nurses or contract for nursing services. This would allow a local nurse to actually visit the home when necessary and review medical records. This is not a novel idea. We have been told that juvenile courts in Iowa have ordered county nurses' involvement in some court cases. We have also found other county and state child welfare agencies that employ nurses. For example, Mercer County [Pennsylvania] Children and Youth Services investigates child abuse reports and has employed a full-time nurse for over a decade. The nurse is responsible for reaching out to doctors and interpreting their reports. The nurse also goes to homes to evaluate the children and conduct weight checks if warranted. A supervisor at Mercer County described their nurse to our office as a "huge benefit" to their case workers and for case management.

Once again, we believe that increasing record-retention timeframes by adopting laws similar to those in New Hampshire and Indiana would help DHS staff better identify patterns of child

abuse. See page 49 of this report for additional information on New Hampshire and Indiana laws.

The Ombudsman recommends that DHS:

4. **Conduct training for field workers to help them identify signs of malnourishment and when it is necessary to refer a child to a physician for evaluation.**

5. **Utilize readily-available medical professionals for consultation on cases, including cases of alleged malnourishment. This could be accomplished by:**

    a. **Employing or contracting with medical professionals who are available to staff cases of malnourishment;**

    b. **Establishing a Medical Help Desk similar to the Service Help Desk; or**

    c. **Contracting with Iowa's county public health agencies.**

Daycare Licensing Compliance Visits: 2015-2016

Child-development homes are required to have annual unannounced compliance visits.[136] The last two home annual compliance visits at the Rays' daycare occurred on December 4, 2015, and December 1, 2016, and were handled by the same DHS daycare licensing worker.

DECEMBER 4, 2015

The daycare licensing worker documented the December 4, 2015, visit through DHS's "Checklist for Child Development Home Registration."[137] According to this document, the Rays' daycare was found to be out of compliance for not having the phone numbers for police, fire, ambulance, and poison information posted by the phone; not having the numbers for each child's parent, physician, and a responsible person accessible by the phone; and not having the emergency parent contact information in travel vehicles.

It was also noted that the Rays' first-aid kit did not contain disposable tweezers, and daycare records did not include physical examination reports for all children, nor immunization records for one child. Certain training and certification information was also found to be out of compliance: cardiopulmonary resuscitation (CPR) training expired in October 2015, and there was no training completed during the renewal period (12 hours of training is required for each year).

Lastly, the daycare licensing worker documented that not all adult household members had physical examination reports available.

Though there were certain areas out of compliance, she found that the corrections did not require a follow-up home visit. Instead, it was requested that the Rays make the necessary corrections and self-certify these corrections to DHS by January 19, 2016. According to DHS records, Misty signed a document on January 18, 2016, certifying that she had taken all the steps necessary to correct each of the identified violations.

DECEMBER 1, 2016

The next home-compliance visit was conducted almost one year later on December 1, 2016. DHS's checklist for child-development home registration showed that the Rays were out of compliance in several areas.[138]

The daycare did not have documentation of physical examination records for nine children, or immunization records for six children. The daycare also was not tracking hours of substitute employees. All other areas on the checklist were found to be in compliance or were not applicable.

The daycare licensing worker noted that the issues did not require a follow-up home visit, but needed to be corrected by February 6, 2017. In a letter to Misty following the visit, dated

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[136] IOWA ADMIN. CODE r. 441—110.4.
[137] DHS, *Checklist for Child Development Home Registration*, 470-0625 (December 4, 2015).
[138] DHS, *Checklist for Child Development Home Registration*, 470-0625 (December 1, 2016).

December 15, 2016, the worker noted that she would "verify corrections have been made during the next annual compliance check."

The December 1, 2016, home-compliance visit was the last time DHS was in the home prior to Sabrina's death 162 days later on May 12, 2017.

ANALYSIS

One question we considered when evaluating the home-compliance visits from 2015 and 2016 was whether the areas that were found to be out of compliance should have required a follow-up home visit to confirm that corrections had been made, rather than self-certification. According to DHS policy, there are certain circumstances where follow-up home visits are required to certify that all out-of-compliance areas have been corrected. The areas include, but are not limited to:

- ♦ Missing several fire or safety measures: no exit plans, alarms missing, wrong extinguisher, etc.
- ♦ Extensive failure to maintain child file documentation.
- ♦ Failure to be in compliance with areas that were out of compliance at time of the previous annual inspection.
- ♦ Substantial concerns of general noncompliance with checklist.
- ♦ Concerns regarding over numbers or general supervision.
- ♦ Concerns regarding safe sleep practices.
- ♦ Concerns for outdoor safety (pools, fencing, hazards, etc.).
- ♦ Concerns regarding children's access to unsafe materials.
- ♦ Physical location concerns such as electrical cords, fire hazards, smoking in the home, etc.
- ♦ Lead concerns.
- ♦ Anything else that requires visual inspection in the home to verify compliance.[139]

First, a follow-up home visit is required when there has been "extensive failure to maintain child file documentation."[140] Policy further explains that the "child file" includes: identifying information, emergency information, medical consent from parent, physical examination report,

[139] DHS's Employees' Manual, Title 12, Chapter F, Page 52.
[140] *Id*.

immunization certificate, list of authorized pick-up people, permission from parent to attend activities, and injury report forms.[141]

In both of the Rays' 2015 and 2016 home-compliance visits, there was information missing from the child files, including physical examination records and immunization records. In 2015, the daycare licensing worker also documented that the emergency parent contact information was not in the daycare's travel vehicles.

Considering the number of records and information contained in each child's file, it is difficult to say whether the missing information in home-compliance visits were "extensive." Regardless, a follow-up visit should have been required after the 2016 visit based on the worker's finding that child files were still missing physical examination reports and immunization records. The policy specifies that "Failure to be in compliance with areas that were out of compliance at time of the previous annual inspection" *requires* a follow-up visit.

> We also considered whether the daycare licensing worker followed policy by observing all the rooms in the Rays' home … We believe that this requirement was specifically relevant to the case, based on the condition of the girls' bedroom at the time of Sabrina's death.

We also considered whether the daycare licensing worker followed policy by observing all the rooms in the Rays' home during the daycare compliance visit. Under a heading labeled "Indoors," DHS policy states that "all rooms should be observed for compliance. If a room is inaccessible, ask for entry. If entry is denied, document and talk with your supervisor."[142]

We believe this requirement was specifically relevant to the case, based on the condition of the girls' bedroom at the time of Sabrina's death. If such deplorable conditions – evidence of a lock and alarm on the bedroom door, boarded up windows, no mattresses, evidence of carpet hastily ripped out, toddler potties on the floor – existed at the time of the home-compliance visits, this certainly would have raised red flags.

We asked DHS where on the checklist daycare licensing workers note that they have observed all of the rooms in the home for compliance. DHS responded that workers document this by checking "yes" or "no" next to a box that states, "Conditions in the home shall be safe, sanitary, and free from hazards." DHS's response further explained that, "To verify that a home is safe, sanitary, and free from hazards, the worker must observe the home in its entirety. The program is required to be located in a single-family residence by code. We register the entire child development home address, not only the child care space."

In the 2015 and 2016 Checklists, the daycare licensing worker checked "yes" next to the box stating, "Conditions in the home shall be safe, sanitary, and free from hazards."

However, when we interviewed the worker, she stated that she examined only the lower level of

[141] DHS's Employees' Manual, Title 12, Chapter F, Pages 22 – 24.
[142] DHS's Employees' Manual, Title 12, Chapter F, Page 53.

the home where the main areas of the daycare were found. She admitted she did not examine the second floor of the home. She explained that her typical practice was to observe the rooms in the home that are relevant to daycare, unless she has suspicions of something going on.

The daycare licensing worker told us that the home was "clean and appropriate," and she did not recall seeing any of the Ray children in the home. She does not recall specifically if she saw Sabrina during the December 1, 2016, home-compliance visit.

Based on the description of the scene on May 12, 2017, the Perry law enforcement officers found Sabrina deceased in a downstairs bedroom, which was located off the dining room and away from main daycare play area.[143] The information we received does not suggest that this bedroom was examined during the home-compliance visit.

We asked DHS for clarification on when daycare licensing staff were given instructions on the requirement to observe all the rooms in the home. We were told that DHS policy was updated in September 2016 to include the requirement that all rooms be observed for compliance.

However, DHS maintained that staff were actually informed of the requirement prior to the formal change to policy. Specifically, DHS stated that staff were informed during a conference call on July 23, 2014, as well as through newsletters that are issued to providers and staff in the June 2014 and September 2014 editions. Lastly, DHS informed us that staff were again notified of the requirement to observe all rooms in the daycare home for compliance when the policy was updated in September 2016.

Asked whether there was specific training on the requirement after the policy was updated, DHS responded that "the expectation was not a new requirement. No specific training occurred outside of ongoing communication" such as conference calls, manuals, and face-to-face meetings.

DHS did share that the requirement to observe all the rooms in the daycare for compliance is covered in a "SW 401" training course, which is offered to all social workers who do complaint and compliance checks in child-development homes. According to DHS, "all current supervisors and workers responsible for these checks have completed this course."

> She did not recall receiving training to observe all of the rooms in the home for compliance until June 2017, a month *after* Sabrina died.

We presented this information to the daycare licensing worker during our interview. In response, she explained that she did not recall receiving training to observe all of the rooms in the home for compliance until June 2017, a month *after* Sabrina died. Particularly, she stated that there was a huge push in June 2017 for workers to inspect all the rooms in homes during compliance checks.

During an interview with former DHS supervisor Chappelle, who oversaw daycare licensing workers, we asked whether he recalled daycare workers receiving notice of the direction to observe all the rooms in a home. He did not recall, though he shared that "there was so much stuff going on all the time, I'm not

[143] Mandatory Reporter form submitted by Dallas County EMS paramedic, May 15, 2017.

surprised people missed that. [The daycare licensing worker] was a conscientious worker. If she missed it, it was genuinely because she didn't know." Chappelle elaborated:

> The Department can point to a newsletter, but workers didn't always see that stuff. You had tons of information coming across your computer through email, and you'd go to meetings, something like that. When you look at it in this case, that's a really critical piece, but in the scheme of things, you weigh that against the 100 other things that were on the checklist, it's a small thing on the checklist, and if it wasn't on the checklist, you have to depend on somebody reading a newsletter, or on a CIDS call that maybe somebody missed, or they came on late, or somebody else on the CIDS call was doing something distracting. There are 100 different ways that [the daycare licensing worker] could have missed that.

DHS informed us that they had not discovered until after Sabrina's death that the daycare licensing worker had not examined all of the rooms in the home during the 2016 home-compliance visit. Asked whether the worker's handling had been reviewed, DHS responded that "there was an informal review of the worker's handling of the last compliance visit." As a result, DHS explained that she "was coached by the supervisor regarding the necessity to observe all rooms."

The worker reporter to us that one of the biggest obstacles in fulfilling the duties of a daycare licensing worker is not having enough staff to do the job.

We also considered whether the pressure of high caseloads could have impacted the daycare licensing worker's ability to complete a thorough review of the home. The worker reported to us that one of the biggest obstacles in fulfilling the duties of a daycare licensing worker is not having enough staff to do the job. She stated that there is high employee turnover within the area, and on top of that, there are 800 to 900 registered and non-registered clients in the Des Moines area that workers have to see. She stated that the unit has only two full-time and one part-time workers tasked with completing these visits.

The daycare licensing worker shared that it is very hard to meet every daycare provider on their caseload, when there are also "time sensitive" pre-inspection visits and complaint visits to be done. She explained that the unit "could definitely benefit from an additional one or two individuals helping." However, it was her impression that the Des Moines Service Area believes that the unit is fully staffed.

Chappelle shared similar sentiments regarding the caseloads of daycare licensing staff. We shared the numbers that the daycare licensing worker provided and asked if the information shocked him. He replied:

> We just busted our butts to do that. I'm not shocked by anything with the Department after 40-some years with them. **There was always way more than you can do.** … It's more ridiculous than it was shocking. Again, you know, we

> say we care about kids, it's not how we spend our money. Not that I needed five daycare workers … but at least make people's workload doable. (Emphasis added.)

We requested and received statewide numbers from DHS for daycare licensing staff in calendar years 2015 to 2018. The total number of daycare licensing checks conducted during 2015, the year of the second-to-last visit to the Ray home, was 4,977. Of that number, 3,482 checks were completed on child-development homes. Each worker's average annual caseload was 219, and the average month's caseload was 18.

In 2016, the year of the last visit to the Ray home, the total number of daycare licensing checks conducted was a bit lower, at 4,756 (child-development homes were 3,193). Each worker's average annual caseload was 209, and the average monthly caseload was 17.

The numbers for 2017 increased to 5,590 checks conducted by daycare licensing staff (4,044 of which were child-development homes), with an average annual caseload of 246, and average monthly caseload of 20. DHS explained that this increase was the result of changes made to the Federal Child Care Development Block Grant regulations, which added new requirements for non-registered homes – specifically, that non-registered homes be subject to compliance checks, when checks were previously only required for registered homes.

DHS further explained that since the implementation of the block grant regulation changes, "many non-registered homes have chosen not to continue their child care businesses," which ultimately brought "the number of homes where compliance checks are needed back to the level they were prior to 2017."

The documentation provided by DHS supports this assertion: in 2018, there were 4,574 checks completed by daycare licensing staff, 2,996 of which were child-development homes. The average annual caseload for workers was 201, while the average monthly caseload was 17.

CONCLUSIONS AND RECOMMENDATIONS

Based on the information contained in DHS's 2015 and 2016 checklists for child-development home registrations, we believe that a follow-up home visit should have been required following the December 1, 2016, visit to the Ray home. Because the licensing worker found that the daycare was out of compliance in 2015, and again in 2016 for having incomplete information within its child files, policy specifies that a follow-up visit was required to ensure that corrections were made.

We determined that the daycare licensing worker was sincere in her testimony to us that she did not recall being given the instruction to observe all the rooms prior to her home visit on December 1, 2016. While we also found no information to suggest that DHS was lax in providing direction to its workers, it appears that the direction was perhaps insufficient. Had this directive been clear and the rooms examined, we believe it is likely that the worker would have seen Sabrina and her siblings. As a mandatory reporter, the physical conditions of the children could have raised concerns warranting a child abuse report.

Outlining the requirement in the checklist to examine all rooms during compliance visits would not only clarify the instruction, but also ensure that licensing workers document their work during home visits.

DHS should also consider the sentiments of Chappelle and daycare licensing staff who are concerned with caseloads in the unit.

The Ombudsman recommends that DHS:

6. **Provide additional training to all daycare licensing staff to ensure that workers know when a follow-up visit of a home is required due to non-compliance.**

7. **Include in the checklist for child-development home registration a specific box for observing all of the rooms in the home for compliance.**

8. **Evaluate the adequacy of daycare licensing staffing levels. If DHS concludes that daycare licensing is not sufficiently staffed, it should ask the Council on Human Services to make any required personnel and budgetary requests to the Governor and General Assembly.**

Sabrina's Death and Subsequent Reports

Following Sabrina's death, DHS received multiple child abuse reports concerning Sabrina and her siblings. The first report was made by the Dallas County Emergency Medical Services first responder Sam Hofer. The intake report stated in part:

> It is alleged Sabrina (age 16) was found dead at her home on 5/12/17. The death is suspicious as child appears very malnourished and looks to be 60 pounds at the most. Denial of Critical Care failure to provide adequate food is alleged.
>
> … ADDITIONAL INFORMATION:
> Reporter said child is malnourished, anorexia or bulimic or something she can weigh at the most 60 pounds. Parents left for vacation and grandmother Carla Bousman is at the home caring for the children as is a cousin Josie that lives in the home. Grandma said child was up and talking at 6:15 and when they went and check on her several minutes later she was not responsive. Reporter said the grandmother talked of child being locked in a closet and duct tape over her mouth by biological mother and placed with and adopted by this family.

Several other reports were received in the days following Sabrina's death, one of which alleged that Marc and Misty locked the girls' bedroom door, and the children were fed only oatmeal three times a day for a week. Through the course of this assessment, another allegation arose that Marc sexually abused one of Sabrina's sisters.

A separate report was made alleging that Justin Ray physically abused Sabrina by pushing her down the stairs and punching and stomping on her head. A bruise was discovered on Sabrina's head and chin after her death. This reporter also alleged that the family's nickname for Sabrina was "fuck tard."

Another reporter contacted DHS with allegations that Carla Bousman and Josie Bousman (the grandmother and cousin, respectively) were depriving Sabrina and her sisters of food. The reporter alleged that the relatives delayed contacting emergency services when Sabrina was in "significant medical distress."

Only one report was received with Sabrina's minor adopted brother as the child victim[144] – it was alleged that Marc and Misty had instructed Justin Ray to "rig vehicle exhaust inside the car while Marc, Misty, Justin, and [minor child] (age 10) were in the car, in an attempt to kill the family members." This incident occurred in Tennessee while some family members were on their way to Disney World. Evidence gathered by law enforcement suggests that shortly after learning of Sabrina's death, Marc and Misty anticipated that they would face criminal charges and took extreme measures, including this attempt to kill themselves, and disposing of all of the family member's cell phones.[145]

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[144] According to the police report, in an interview following Sabrina's death, Misty shared that the minor adopted boy was the "highlight" of her life and was the "unifier of the family." It is clear that he was treated much differently than Sabrina and her sisters in the home.
[145] Linh Ta, *Warrant reveals details from night Sabrina Ray died,* Des Moines Register, September 26, 2017.

During the course of these assessments disturbing information was revealed about the abuse that had occurred in the Ray home. In an interview with a school official, it was learned that Sabrina appeared to be well taken care of once she was removed from her biological family and placed with the Rays. However, once Sabrina was adopted, the concerns began when Marc and Misty started to home-school her. According to DHS's Confidential Briefing, Sabrina was pulled from school to be homeschooled on the same day as her adoption on January 31, 2012. DHS records indicate that she went back to school in August of that year, but was removed permanently from school in September 2014, at the age of 13.

Sabrina's sisters reported that they were locked in their bedroom for days, without bedding or mattresses, and were forced to wear diapers. In reference to the alarm on the bedroom door, one of the girls told law enforcement that the alarm is there because "we sneak out of the bedroom because sometimes they don't feed us." The children reported that there were times when they were not fed for three or four days at a time, and did not always receive water. The children resorted to stealing food from trash cans and hiding the food in their diapers. An adopted sibling reported that Marc would check for food in the diapers, and in doing so, would sexually abuse her.

Both girls were hospitalized for malnutrition following Sabrina's death. At the time of Sabrina's death, the 12- and 10-year old weighed 44 pounds and 21 pounds, respectively.[146]

The surviving children also made disturbing comments about the coaching they had received. The sisters reported to first responders that Marc and Misty had directed them to lie to DHS and "say that everything was fine and dandy … it's all PG, rainbows and sunshine instead of saying what really goes on in the house." Even more disturbing, the girls also explained that if they did not say everything was okay, Marc and Misty would "cause us more pain."

The girls explained that if they did not say everything was okay, Marc and Misty would "cause us more pain."

This same concern was once raised by a reporter, who was suspicious that the girls were trained to give certain answers, during the November 25, 2014, call to CSIU. The reporter stated: "if someone goes in there and just asks questions, or asks her it's going to appear to be a certain way because I know that they've been trained – I mean for lack of better words – trained to do what they've been doing there for a while."

Additionally, law enforcement learned after Sabrina's death that Marc and Misty would go as far as to place a plate of food in front of the children when a DHS worker came to the home, and immediately take it away when the worker left. The act of staging the home for a DHS visit was reported in a child abuse call on May 7, 2014. The allegation was that "whenever a DHS worker would come, the punishment would stop until he left and it would resume when this worker left."

[146] DHS's Confidential Briefing. DHS documents that the sister who weighed 21 pounds at the time of Sabrina's death was seen by a medical provider through the University of Iowa Hospitals and Clinics in October 2013 and weighed 27 pounds.

All the child abuse reports against the Rays that were received and accepted for assessments following Sabrina's death resulted in founded child abuse. Based on the information provided to us, the founded child abuse allegations broke down as follows:

- Misty had founded allegations for "denial of critical care – failure to provide adequate food/adequate medical care/proper supervision;" and physical abuse.
- Marc had founded allegations for "denial of critical care – failure to provide adequate food/adequate medical care/proper supervision;" physical abuse; and sexual abuse.
- Justin had a founded allegation for physical and sexual abuse.
- Carla had founded allegations for "denial of critical care – failure to provide adequate medical care/proper supervision."
- Josie had founded allegations for "denial of critical care – failure to provide adequate medical care/proper supervision."

In addition to the reports received alleging child abuse by Marc and Misty against their adopted children, there were also several reports of physical abuse against daycare children following Sabrina's death. One report alleged physical abuse – two abrasions on the top of a 3-month old's hand – that occurred in November 2016, seven months prior. Another report alleged physical injury to a 1-year old's face that took several days to heal. The grandmother of this child explained that she saw the injuries – which occurred in March 2017 – but did not want to call DHS because she "didn't want to be the one to cause trouble for Marc and Misty, as everyone in town loved them."

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Another assessment that was also initiated for a physical abuse allegation found that a child lost weight while in the Rays' daycare and would come home every day "very thirsty" and state, "me hungry me not eat today." The child had attended the daycare for five years and had been removed a couple of months before Sabrina's death.

Yet another report alleged that a child was physically abused while at the Rays' daycare. During the course of the assessment, it was also discovered that the child – who had attended the daycare for nearly three years – would come home hungry "to the point he would scream until he got something to eat." The mother told DHS that the Rays were the only daycare in town that had an opening at that time.

Twenty-four days after Sabrina's death, on June 5, 2017, the Rays received notice that their daycare license was revoked. DHS determined that the daycare had been operated in a manner

that "impairs the safety, health, or well-being of the children in care" and "does not comply with child development home laws and rules…"[147]

The reports concerning the daycare children paint a clear picture that issues had been occurring in the home long before Sabrina's death. However, with the exception of one complaint from a parent to daycare licensing in September 2013, DHS provided no documentation to suggest that any such issues or concerns had been raised to DHS prior to May and June 2017.

We did not identify any procedural or efficiency problems by DHS staff after Sabrina's death.

[147] DHS, *Notice of Decision: Child Care*, 470-4558 (May 26, 2017).

Communications Between DHS Units

> There was always something kind of weird there. We could never put our finger on it, but there was always something off there. … There was something that was just not copasetic … It was just kind of like, yeah, it's there – keep an eye on it.
>
> *Former DHS Social Work Supervisor Mark Chappelle*[148]

This report has illustrated that DHS staff in separate units of the agency communicated inefficiently or not at all with one another regarding the child abuse reports against the Rays. Though we have already touched on this topic, we believe a broader review of the communications and staffings within DHS prior to Sabrina's death on May 12, 2017, warrants its own findings and conclusions.

2010

Following the 2010 assessments of child abuse allegations, DHS voiced concerns about the Rays, enough so that it was determined by the Western Service Area that a corrective action plan should be implemented. Shortly after the final assessment was completed in 2010, however, Marc and Misty had moved back to Perry, out of the Western Service Area. It was then recommended to the Des Moines Service Area to implement and monitor a corrective action plan for the family. It is our understanding that this did not occur.[149]

2014

DHS was most heavily involved with the Ray family in 2014. As such, it was the year that required the greatest need for intra-department communication.

After the first child abuse report in April, a formal staffing occurred among staff from foster care licensing, ongoing-services, and field staff where it was decided that the foster care children would not be removed from the home. Regardless, DHS SAM Pat Penning gave the direction that "this home was not to be used and would not be used in the future."

Another formal staffing occurred in May after another child abuse report was filed, that time between foster care licensing and ongoing-services. Social work administrator (SWA) Mike McInroy directed the ongoing-services worker to interview the current foster care children about the specific concerns identified in the rejected intake, and to touch base with service providers.

Information provided to us suggests these directives were not followed. Two of the foster care children were interviewed, but questions were not asked concerning the specific allegations. The service providers were not contacted.

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[148] From our interview with Mark Chappelle on December 18, 2019.
[149] Telephone call with a DHS prevention program manager on March 2, 2020.

Five weeks later, the DHS ongoing-services worker was notified that one of the foster care children – the youngest – had suspicious bruising that was believed to be inflicted by the Rays. We received no information to suggest that this was relayed to foster care licensing.

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Foster care licensing did receive notice that a child abuse report was made on July 5, 2014, concerning suspected bruising on the foster child. The field worker handling the assessment did contact the ongoing-services worker *who shared that she sees the children regularly and had no concerns* – even though weeks prior she was notified of the suspicious bruising.

Field workers handling the July 5, 2014, child abuse assessment did not contact Messersmith, despite her being an obvious collateral witness for a child abuse report concerning a foster care child.

Additionally, the field workers handling the July 5, 2014, child abuse assessment did not contact the Mid-Iowa FSRP services worker, Shelby Messersmith, despite her being an obvious collateral witness for a child abuse report concerning a foster care child. In this particular case, Messersmith was knowledgeable of the issues occurring in the Ray home, and would have been an extremely significant source of information.

Several weeks after this series of reports was received, SAM Penning was again involved and requested SWA McInroy take a closer look at the Rays. The next email is dated nearly two months later. It indicates that Penning had not received McInroy's findings on the family, and she asked that the information be brought to their next one-on-one meeting. We were not able to locate any further email exchanges on this subject and Penning could not recall what she discussed with McInroy or the outcome of that meeting.

There is no indication that foster care licensing received notices of the November 2014 or November 2015 reports, even though the Rays still had a foster care license. Likewise, it does not appear that any further staffings on the matter occurred between any employees within DHS.

One interviewee suggested that further staffing had not occurred because the agency already "decided how things were going to roll," meaning no more foster care children would be placed in the home. We asked whether foster care licensing staff would even have received notice of the November 2014 and 2015 child abuse reports, since there were no longer foster care children in the home. The interviewee responded: "It would be difficult given all of the discussion with the Rays, that foster care licensing would not have found out one way or another."

All of these disparate responses to reports at the Ray home caused us to consider whether DHS staff from different units were invested in one another's success – not just whether the right hand *knew* what the left hand was doing, but whether the right hand *cared* what the left hand was doing. During an interview with a former employee, we asked about the mentality among the

different departments of DHS. In response, the interviewee shared some exceptionally significant insights:

> I don't think anybody in the Department wants to see something bad happen to a kid or to a family, or to another DHS worker, but when I left the Department, at least in my service area, people were not invested in other people's success. I might know something that will help you do your job, I might tell you about that.
>
> But then again, I might not, depending on what unit you were with, who your supervisor was, what our daily interactions might have been, whether those were positive or those were negative. If I was aware of a policy recommendation and I thought just quite frankly my ass was going to get in the ringer if I didn't do something, then I was going to take care of it. **But if – I think sometimes, maybe often times – if there was not a specific requirement for me to talk to you about something, then I might not do that**.
>
> It was difficult to think in the broadest picture. And if we were doing that, then my god, look at all this stuff going on, we need to get together – that didn't always happen. I don't want to say people were malicious, because I don't think that was the case. **I think sometimes people were myopic, and suffered from 'this is my area and this is what I need to get done, and I'll take care of that if I have time.' … But being invested in somebody's else's success – in my CPWs, in my workers, in my unit, in the next county – if we were all thinking that way, some of this stuff wouldn't have happened**. … If we examine these things in a just culture, that's where we can answer some of these questions. (Emphasis added.)

DAYCARE LICENSING

We received no information to suggest that a referral was made to daycare licensing staff for any of the 11 child abuse reports received between 2010 and 2015, with the exception of the April 10, 2014, intake.[150]

We received no information to suggest that a referral was made to daycare licensing staff for any of the 11 child abuse reports received between 2010 and 2015, with the exception of April 10, 2014, intake.

According to DHS, referrals are made by either the intake unit or the field worker handling the assessment. However, a CSIU intake worker acknowledged to our office that it is not always done. A daycare licensing worker similarly acknowledged that referrals are supposed to be made on both rejected and accepted intakes, but sometimes they "fall through the cracks."

We asked former DHS supervisor Mark Chappelle how daycare licensing staff received notice of

[150] DHS's Employees' Manual, Title 12, Chapter F, Page 64. "When it is alleged that child abuse has occurred in a child development home, the protective service worker will immediately inform the child care registration worker."

child abuse reports. Chappelle explained that referrals were made to him, and he then passed on the information to his workers, who would conduct a home visit either with the field worker during the initial visit, or afterwards. We asked how Chappelle actually received referrals on child abuse reports. Chappelle could not recall specifically, but remembered that he did receive some sort of notification of a report being made.

When we asked Chappelle why referrals were not made to daycare licensing, he was not sure, but emphasized that there was no question that a daycare licensing worker was going to get into the home once a referral had been made. "Yes, if I got a referral on a daycare home, I was wanting the licensing workers to go."

Asked whether he believed the lack of daycare licensing involvement following the Ray child abuse reports was an issue on the referral end, he replied, "I would like to think so because I'd like to think I wouldn't let something like that get by me."

Lack of Internal Investigation Following Sabrina's Death

We are also concerned about the lack of an internal investigation by DHS following Sabrina's death. DHS provided no explanation as to why a formal review had not been completed. Considering the extent of DHS's involvement with the family and the tragic outcomes, it seems such a review would have been in order.

Chappelle acknowledged that he was surprised no internal investigation took place: "Usually after something like that we would want to talk to everybody who touched this in the last five years."

We believe an internal review could have greatly benefited DHS to shed light on mistakes and spur discussion on future improvements. Throughout our investigation, we asked every interviewee whether he or she had any ideas on how to improve Iowa's child protection system, so that something like this never happens again. We received a number of answers relating to staffing. One answer that stuck out to us, however, regarded DHS's overall view on how to handle the aftermath of a tragedy like a child death. We believe the insight was so important, we have included much of the direct quote in this report:

> There is a decision-making process that goes on with workers, however, when something like this happens or when Natalie Finn happens. When we go at these, we as the Department, it's blame-based – who screwed up? That's what we go after, and we lose a lot of valuable information, I think, when we go after people like that. The Department would say we aren't looking to fix blame, but I've been through too many through the course of my career – that's exactly how that happens. [It's] certainly an impression with workers because everybody hunkers down during one of those.

The Department would say we aren't looking to fix blame, but I've been through too many through the course of my career – that's exactly how that happens.

> If you could create a just culture for examination of these things, I think you'd learn a lot about the dynamics that drive decision-making in these cases. And so many times, it's not based on what was best in the case, it was based on work pressures, impressions on the family, worker bias, supervisor bias, department bias, the law, politics – all of those other things that impinge on workers' decision-making, and we end up with bad situations like this. But if we don't look at them, and look at them honestly, we're never going to discover those dynamics and how to stop that stuff from happening.
>
> If someone commits gross negligence – whether it is a supervisor or a worker – [and] they do something intentionally to harm a family or a child, then yeah, you need to be gone. But short of that, I think the idea that somebody did something wrong all the time is just the wrong way to come at this. … It puts people on the defensive. You don't get the information that would help you understand what it is that drives those things. … People want something done, and somebody's going to hang.

We considered how other states handle internal investigations following the death of a child. Oregon, for example, implemented a new law[151] earlier this year that creates Critical Incident Review Teams in cases where the death of a child may have been from child abuse. The team is required to submit a written report to Oregon's Department of Human Services no later than the 100th day following the date they were assigned the case. There is a list of criteria the report must include. Unless releasing the information will compromise a criminal investigation, specific portions of the report are then published on a website.

CONCLUSIONS AND RECOMMENDATIONS

The Rays were subject to significant oversight by DHS. They operated a licensed daycare that involved 112 children in and out of the home over the course of 13 years. The Rays were licensed foster care parents for nearly 10 years and accepted a total of 23 placements.[152] The Rays adopted four children from foster care. Between 2006 and 2017 adoption subsidies, foster care subsidies, and child care payments from the State of Iowa to the Rays totaled over $640,000.

DHS was further involved with the family due to numerous child abuse reports – 11 within a five-year span. To the extent possible, there were plenty of official eyes and ears on this family.

> To the extent possible, there were plenty of official eyes and ears on this family.

We cannot dispute the notion that Marc and Misty Ray were skilled manipulators who knew how to work the system. With two parents involved in the day-to-day home life, it would have been very easy to stage the scene to make it appear nothing was awry, even when a DHS worker made an unannounced visit.

[151] https://olis.leg.state.or.us/liz/2015R1/Downloads/MeasureDocument/SB832/Enrolled.
[152] DHS's Confidential Briefing.

Testimony from the surviving children confirmed what several reporters suspected – that the Rays had coached the children in their home to provide acceptable answers to DHS's questions. DHS did not receive honest answers during its investigations at the home into allegations of "physical abuse" and "denial of critical care."

How does DHS protect children when allegations of abuse have not been proven? The answer lies in active and productive communications among child welfare workers who have regular interactions with families. These communications should include a broad overview of what the specific concerns are with the family and how those concerns can be addressed.

When it came to evaluating the Rays, former DHS supervisor Mark Chappelle seemed to sense something was not right, and that DHS needed to keep an eye on the family. We asked Chappelle if he believed that the Rays were just adept at working the system. He responded:

> Well you had to give people due process. You couldn't say to someone, 'I can't give you a foster care license because we think you're weird.' It's not right to do that to people, that shouldn't happen. The decisions we make about how people can care for others shouldn't be based on our intuition. You've got to prove your case. So many times, the concerns we had about people were these gut-kind of feelings. You'd have a lot of smoke, but you'd never have the flame.

However, the numbers tell quite a different story – a story that we believe goes beyond a gut-feeling that the Rays were just "weird."

Between 2010 and 2015, there were five child abuse reports concerning the Rays' adopted children, Sabrina and her two sisters.[153] For the reports that we received records on, each report alleged physical abuse or failure to provide adequate food, or both. Specifically, three of these reports alleged that Misty and/or Marc beat the children, required them to fight each other for food, and subjected them to other severe punishments. Three of these reports – including the most recent report a year and a half before Sabrina died – alleged that Marc and Misty did not feed the girls.

During the same time period, there were six child abuse reports concerning foster care children who were currently or formerly placed in the Ray home. One report concerned physical abuse against a foster care child placed in the home. Two of the reports alleged the Rays subjected the foster child to severe punishments. One of the reports alleged that the foster child was made to eat his own vomit and had lost weight while in the Rays' home.

None of the child abuse reports concerning Sabrina and her sisters resulted in a founded assessment. Nor did any of the child abuse reports concerning foster care children result in a founded assessment.

[153] Between 2010 and 2015, there were a total of 11 child abuse reports made, the remaining six were concerning foster care children.

Further, we found that efforts were made to raise concerns about the Rays among different DHS units, particularly between foster care licensing, ongoing-services, and field workers (when they were involved). When it came down to it, there was not sufficient communication between everyone.

When it came down to it, there was not sufficient communication between everyone.

We also found there was very limited involvement with daycare licensing staff. In particular, we found that the daycare licensing staff was either not receiving the referrals, or the home checks were generally not being completed. DHS's Employee's Manual specifies that when child abuse allegations are made about a child-development home, licensing staff must treat the concerns as a complaint and conduct a home visit. According to DHS, referrals to daycare licensing are made by the intake staff, or the field worker handling the assessment. However, based on the testimony to our office, we question whether there is sufficient protocol for the referrals to be made.

In addition to daycare licensing's lack of involvement, we also found that there was a failure to include the FSRP services worker, Messersmith, in DHS's staffings. Messersmith was not only familiar with the home, she also had raised numerous red flags throughout her time with the Rays. As the FSRP provider who had expressed concerns about the family, Messersmith's knowledge and opinion would have been exceptionally important to consider.

Messersmith was also not included in the conference call between Hoffman, Chappelle, and Social Work Administrator Tracy White on June 17, 2014, after DHS learned of the bruising concerns Messersmith had raised. Further, Messersmith was not included in the July 9, 2014, staffing following the accepted intake received on July 5, 2014 regarding bruising that was initially identified by Messersmith weeks prior. Messersmith was also not contacted as a collateral witness by the field workers handling the child abuse assessment that followed.

We found that DHS's failure to include Messersmith in the staffings was unacceptable, though it was hardly surprising considering the events at that time. We found that DHS not only failed to consult with Messersmith, but, along with her supervisor, actively discouraged her from speaking up.

Promoting awareness and developing communication protocols between the different DHS units would be extremely beneficial and could save a child's life in the future.

In addition, we believe that both external and internal reviews of child deaths are critical in identifying problems.

As noted in our investigation of the death of Natalie Finn, there are other government bodies – particularly the Child Fatality Review Committee – that could have reviewed DHS's actions in this case. After the death of Shelby Duis in 2000, Iowa lawmakers approved a new law authorizing the creation of an ad hoc committee to investigate DHS-related child fatalities.[154]

[154] IOWA CODE § 135.43(4).

The law authorizes the State Medical Examiner to establish a Child Fatality Review Committee (CFRC) to "immediately review the child abuse assessments which involve the fatality of a child under age eighteen … to determine whether the department of human services and others involved with the case of child abuse responded appropriately."[155] Since the legislation was passed in 2000, *the committee has never been convened*.

The other potential oversight entities all had significant limitations in their resources and authority. By default, the Ombudsman was the only entity capable of conducting an independent systemic review of DHS's actions. We questioned in the Finn report what the Legislature's expectations are of all these entities – particularly the CFRC – to review child fatalities?

Equally important are internal reviews. An internal review of DHS's interactions with the Ray family following Sabrina's death would have been extremely beneficial to the department. Not only would this have pinpointed what may have gone wrong or what could have been done differently, but also to examine what should be changed and improved within DHS so that further tragedies can be prevented. Even though there was no open assessment at the time of her death (as was the case with Natalie Finn, where an internal review *was* completed), DHS's intense involvement with the Ray family in the months and years prior warranted a departmental review.

The lack of an internal investigation by DHS is unacceptable. Sabrina, her surviving siblings, the foster care children in the home, and the daycare children in the home deserved at least this. Had the Ombudsman not initiated an investigation of Sabrina's death, DHS's shortcomings and failures would have gone undiscovered to both the agency and the public.

DHS needs to develop a protocol for investigating the death of children, especially in cases where DHS has had some involvement.

We have no doubt that making the system better is everyone's goal. The way to accomplish that is through communication, transparency, and self-refection.

The Ombudsman recommends that DHS:

9. **Implement a policy to articulate the protocol for intake staff to refer both rejected and accepted child abuse allegations to daycare licensing staff whenever a child-development home is involved. Ensure intake and field workers are aware of their responsibility to send notifications to the service area so that licensing staff are aware of reports received and assessment initiated on child-development homes.**

10. **Initiate a tracking procedure to ensure that child abuse report referrals are made to daycare licensing staff, and that subsequent home checks are being completed as required by policy.**

11. **Develop an internal tracking and/or notification system to ensure that each unit of DHS that is involved with a family is appropriately communicating the others.**

[155] *Id.*

12. **Create a provision in policy requiring that contracted service workers be included in internal staffings and reviews. The policy should also require that field workers handling assessments communicate with any contracted service workers as collateral witnesses.**

13. **Create a protocol in policy requiring an internal review and a written report by a designated team in situations where DHS reasonably believes the death of a child under the age of 18 was the result of child abuse and:**

    a) **The child was in the custody of DHS at the time of death;**

    b) **The child, the child's sibling or any other child living in the household with the child was the subject of a child abuse assessment within the 12 months preceding the fatality;**

    c) **The child, the child's sibling or any other child living in the household with the child had a pending child welfare or adoption case with DHS within 12 months preceding the fatality;**

    d) **The child, the child's sibling or any other child living in the household with the child was the subject of a child abuse report made to DHS or law enforcement within the 12 months preceding the fatality, whether or not the report was rejected at intake; or**

    e) **The household where the child lived is/was a licensed foster home or provided daycare services.**

    The team's final report shall include a description of any concerns the team has regarding actions taken or not taken by DHS or its contractors in the case.

    The final report shall also include any recommendations for improvements in administration and oversight, as well as training and intervention.

Legislative notification

Pursuant to Iowa Code section 2C.16(3), the Ombudsman is giving notice to the Legislature of the need to re-evaluate its expectations of the Child Fatality Review Committee and other existing child-fatality oversight bodies. Optimally, any reviewing entity would be independent of DHS, have broad access to records and resources, and be adequately funded and staffed to complete comprehensive and detailed reviews of DHS's involvement in child fatality cases. Reviews should be mandatory and the entity would have authority to investigate all aspects of DHS's involvement in a case, including rejected child abuse intakes.

DHS Response

Department of HUMAN SERVICES

Kim Reynolds, Governor | Adam Gregg, Lt. Governor | Kelly Garcia, Director

Office of the Ombudsman Investigative Report (Ray): DHS Response

-June 2020-

Executive Summary

The Department appreciates the Ombudsman's obligation to conduct this investigation, the time and effort expended to produce the report, and the thoughtfulness and seriousness evident in the recommendations. The Department of Human Services (DHS) worked closely with the Office of the Ombudsman to allow full access to our staff and information. DHS values this partnership.

This is the second investigative report published this year by the State Ombudsman reviewing tragic child fatality cases dating back to 2016 and 2017. With one exception, the Ombudsman's recommendations in the most recent report are unique to the Ray tragedy. However, due to the similarities in the cases and the ongoing work from the previous report, DHS' response will address each of the new recommendations and provide an update on our response to the Finn report.

Recommendations

In addition to the steps already taken or in process by DHS, the Ombudsman's Report identified 13 recommendations, which the Department has reviewed and provided responses below:

1) *Modify its administrative rules to increase the retention period for child abuse intakes and assessments as follows.*
   a) *At least five years for rejected abuse intakes, and five additional years if DHS receives another report concerning the same subjects or any siblings or other children in the same household or in the care of the same adults during the timeframe.*
   b) *At least 10 years for "confirmed" and "not confirmed" child abuse assessments, or 10 years from the date of closure of the case file, whichever occurs later. In addition, if DHS receives another report concerning the same subjects or any siblings or other children in the same household or in the care of the same adults during that timeframe, DHS shall retain these abuse assessments for an additional 10 years.*
   c) *Indefinitely for "founded" child abuse assessments.*

Response: This recommendation is consistent with the recommendation in the Natalie Finn report. The balancing of the proper length of time to maintain child abuse information is a valid public policy question for consideration by elected officials. The Department relies on intake and assessment information to protect children. In 2010, the Legislature revised Iowa Administrative Code to change the retention of rejected intakes from six months to three years to provide the Department with more historical information in case of future abuse referrals. The Legislature subsequently established a group to make recommendations for changes in the retention of founded abuse cases. In 2013, legislation was passed which allows for a person's name to be removed

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from the registry after five years (rather than ten years) if they were placed on the registry as a result of physical abuse, denial of critical care, or presence of illegal drugs in a child's system and the child abuse did not result in the child's death or serious injury and they was no subsequent abuse within that five year period.

2) *Create a policy to articulate the protocol for placing a foster family on "hold," and ensure that foster care children placed with a family on "hold" status are removed as soon as possible.*

Response: The Department agrees with the recommendation to create a protocol to guide decision-making around placing a foster home on hold. Placing a home on hold allows the Department to gather additional information with which to make a formal decision regarding continued licensure. However, automatically removing children currently placed in a home on "hold" status and into another home is traumatizing, and requires a thoughtful approach. It may be that removing the children is not always the right answer. Decision documents help guide critical thinking in decision-making and DHS will develop a guidance tool for consistency.

3) *Review the standards necessary to suspend a foster care license, such that the focus is placed on the best interest of the children placed in the home and whether those children are in a safe place.*

Response: The Department agrees with this recommendation.

4) *Conduct training for field workers to help them identify signs of malnourishment and when it is necessary to refer a child to a physician for evaluation.*

Response: The Department agrees with this recommendation. DHS currently provides training on identification of signs of malnourishment and appropriate actions when concerns regarding malnourishment arise. However, we will work to re-emphasize the importance of identification of signs and appropriate response.

5) *Utilize readily-available medical professionals for consultation on cases, included cases of alleged malnourishment. This could be accomplished by:*
   a) *Employing or contracting with medical professionals who are available to staff cases of malnourishment;*
   b) *Establishing a Medical Help Desk similar to the Service Help Desk; or*
   c) *Contracting with Iowa's county public health agencies.*

Response: The Department agrees with this very important recommendation and is exploring implementation options.

The Department has learned that other child welfare jurisdictions outside of Iowa have policies that require children to be observed by a medical practitioner during the course of an assessment, if the allegations include physical abuse or food withholding. DHS will be conducting research on effective policies and practices already developed in other states and is committed to developing corresponding policies and standardizing practice, which would involve engagement with medical practitioners.

6) *Provide additional training to all daycare licensing staff to ensure that workers know when a follow-up visit of a home is required due to non-compliance.*

Response: The Department agrees with this recommendation, drawing the distinction between child development home compliance staff and child care center licensing consultants. DHS will explore policy clarification and additional training opportunities for home compliance staff.

The Department would point out that child care development home compliance staff are responsible for determining whether a home meets all registration requirements such as complete child files, having emergency plans, household member background checks and that the home environment is safe for children. Child protective workers (CPWs) have a somewhat different role in that they are assuring child safety while assessing abuse allegations and trying to determine whether there is a preponderance of evidence to support an abuse finding. A compliance worker is not, as a matter of routine, looking for indicators of abuse and a CPW is not routinely looking for compliance with child development home regulation. However, we see this as an opportunity for better intra-agency collaboration and will explore options to facilitate.

7) *Include in the checklist for child-development home registration a specific box for observing all of the rooms in the home for compliance.*

Response: The Department agrees with this recommendation and will include it in the checklist.

8) *Evaluate the adequacy of daycare licensing staff levels. If DHS concludes that daycare licensing is not sufficiently staffed, it should ask the Council on Human Services to make any required personnel and budgetary requests to the Governor and General Assembly.*

Response: The Department routinely evaluates staffing levels each year as part of its budget request process. DHS currently meets 100% of our annual child care center licensing visits and 96% of our annual child development home visits. Based on this recommendation, DHS will review child care regulatory staff levels with extra scrutiny.

9) *Implement a policy to articulate the protocol for intake staff to refer both rejected and accepted child abuse allegations to daycare licensing staff whenever a child-development home is involved. Ensure intake and field workers are aware of the their responsibility to send notifications to the service area so that licensing staff are aware of reports received and assessment initiated on child-development homes.*

Response: The Department agrees with the recommendation. New manual guidance has been developed and will be published soon. This new guidance is clearer on communication, roles and responsibilities of DHS CPWs and child care regulatory staff when a child abuse allegation is received.

Additionally, since the Finn and Ray cases, we have implemented system changes that better ensure abuse allegations where child care is known to be involved, are relayed to regulatory staff whether the case is rejected or accepted for assessment. The Department is currently assessing the opportunity to develop further technology solutions.

10) *Initiate a tracking procedure to ensure that child abuse report referrals are made to daycare licensing staff, and that subsequent home checks are being completed as required by policy.*

Response: The Department agrees with the recommendation to ensure child abuse reports involving child care are referred to regulatory staff. This data element is currently captured in our electronic data system. In order to systematically track to ensure required regulatory checks are completed, the Department will need to incorporate this functionality into our new Child Welfare Information System, currently in the early planning stages of a multi-year design-build process.

11) *Develop an internal tracking and/or notification system to ensure that each unit of DHS that is involved with a family is appropriately communicating with others.*

Response: The Department agrees with this recommendation to ensure that welfare and child care regulatory staff are notified of abuse allegations that cross functions. The electronic notification is in place today. DHS has existing joint assessment protocols and processes established and will be retraining staff regarding those. As an agency, we will foster more intentional communication and conversation across our divisions. This is a cultural shift with a focus on staffing cases utilizing the variety of expertise within the Department.

12) *Create a provision in policy requiring that contracted service workers be included in internal staffings and reviews. The policy should also require that field workers handling assessments communicate with any contracted service workers as collateral witnesses.*

Response: DHS agrees with this recommendation and acknowledges it is best practice. All partners on a case should be included to gather information that may appropriately inform our actions on a case. We will update policy to address this practice.

13) *Create a protocol in policy requiring an internal review and a written report by a designated team in situations where DHS reasonably believes the death of a child under the age of 18 was the result of child abuse and:*
   a) *The child was in the custody of DHS at the time of death;*
   b) *The child, the child's sibling or any other child living in the household with the child was the subject of a child abuse assessment within the 12 months preceding the fatality;*
   c) *The child, the child's sibling or any other child living in the household with the child has a pending child welfare or adoption case with DHS within 12 months preceding a fatality;*
   d) *The child, the child's siblings or any other child living in the household with the child was the subject of a child abuse report made to DHS or law enforcement within the last 12 months preceding the fatality, whether or not the report was rejected at intake; or*
   e) *The household where the child lived is/was a licensed foster home or provided daycare services.*

   The team's final report shall include a description of any concerns the team has regarding actions taken or not taken by DHS or its contractors in the case.

   The final report shall also include any recommendations for improvements in administration and oversight, as well as training and intervention.

Response: DHS is committed to conducting thorough internal reviews and collaborative discussion, which are essential to identify gaps and areas for improvement, similar to medical peer review. It is important to create a positive learning culture during the review, including explicitly recognizing where decisions were made with ambiguous information or less information than is available with the benefit of hindsight. This hindsight should be used to improve processes moving forward.

Natalie Finn Recommendations: Update

Since the release of the Ombudsman's Investigative Report on the Death of Natalie Finn, the Department continues to work to address and implement those recommendations. We've provided updates below:

1) *Modify its administrative rules to increase the retention period for child abuse intakes and assessments as follows:*
   a) *At least five years for rejected child abuse intakes, and an additional five years if DHS receives another report concerning the same subjects or any siblings or other children in the same household or in the care of the same adults during that timeframe.*
   b) *At least 10 years for "confirmed" and "not confirmed" child abuse assessments, or 10 years from the date of closure of the case file, whichever occurs later. In addition, if DHS receives another report concerning the same subjects or any sibilings or other children in the same household or in the care of the same adults during that timeframe, DHS shall retain these abuse assessments for an additional 10 years.*
   c) *Indefinitely for "founded" child abuse assessments.*

Status Update: We still believe this is a public policy decision best left to the Legislature.

2) *Emphasize to CSIU intake workers the policy expectation to capture a complete and accurate record of the information provided by reporters and the known circumstances of alleged abuse.*

Status Update: DHS implemented this recommendation. This work is ongoing and monitored through case reviews.

3) *Develop a policy for all intakes received by phone requiring intake workers to read their written narrative of the reporter's statements back to the caller before the conclusion of the call.*

Status Update: We agree with the recommendation; however, there is nuance in the approach. We believe a better approach is to summarize the information received and allow the reporter to review the information, agree or disagree with information, and add any additional information. This process is now occurring.

4) *Continue monitoring rates by which intake workers collect information on collaterals and continue stressing the importance of collecting that information.*

Status Update: DHS implemented this recommendation. This work is ongoing and monitored through case reviews.

5) *Update the INTAKE: Structured Interview document to ensure that the section titled "Collateral" actually addresses the expectation for intake workers to routinely collect information about collaterals.*

Status Update: DHS implemented this recommendation, which is complete.

6) *Continue to monitor and solicit feedback from intake workers for any concerns about conducting system checks.*

Status Update: DHS implemented this recommendation. This work is ongoing and occurs during staff meetings.

7) *Update its Employees' Manual to explicitly require intake workers to review all prior intakes and assessments, not just rejected intakes.*

Status Update: This work is in process and expected to be complete by July 1, 2020.

8) *Continue to emphasize the following expectations for field workers to:*
   a) *Contact reporters.*
   b) *Contact non-custodial parents.*
   c) *Contact all necessary collaterals.*
   d) *Open addenda in a manner that is consistent with policy and administrative rule.*
   e) *Conduct safety assessments consistent with agency policy.*

Status Update: DHS implemented this recommendation. This work is ongoing and monitored through case reviews.

9) *Provide training and written guidance on legal tools available to field workers when faced with resistance from parents. More specifically, we believe field workers would benefit from in-depth training on:*
   a) *What an order to compel is.*
   b) *When to consider pursuing an order to compel.*
   c) *How to execute an order to compel with law enforcement with an emphasis on providing no prior notice to the parent(s). The Finn case could be used as a case study on how <u>not</u> to execute an order to compel.*
   d) *The scope of the authority of an order to compel, including what to do if there is resistance from the parent(s) to conducting interviews and/or searching the residence.*

Status Update: DHS developed more in-depth training in consultation with the Office of the Attorney General, which was made available to staff on March 6, 2020.

10) *Ensure its Employees' Manual and any other relevant employee guidance documents (for both intakes and assessments) are updated to clarify the proper handling of child abuse reports about individuals who are already the subjects of an open assessment or an addendum.*

Status Update: This is in process and expected to be complete by July 1, 2020.

11) *Conduct a systemic review of CSIU operations in light of our findings. The review should include:*
   a) *The adequacy of CSIU staffing levels, including whether it is sufficient to allow intake workers to meet DHS's requirements for ongoing training. If DHS concludes that CSIU is not*

sufficiently staffed, it should ask the Council on Human Services to make any required personnel and budgetary requests to the Governor and General Assembly.

b) *Implementing training for CSIU staff with an emphasis on the intake process and ensuring all staff are meeting the department's annual training requirements.*

c) *Tracking and analyzing the usefulness and submission rate of the required written reports from mandatory reporters. If the review confirms the value of written reports from mandatory reporters, then DHS should allow mandatory reporters to submit their required written reports via email or an online form as a means to increase submission rates. If the review does not confirm the value of written reports from mandatory reporters, then DHS should propose legislation to remove that statutory requirement.*

Status Update: We are undertaking this review and if needed, we will make staffing recommendations and propose statutory changes regarding mandatory reporting to the Governor and Legislature this fall. Changes to training can be implemented internally.

12) *Create an online child abuse reporting system for child abuse reports where there is no immediate danger to the child.*

Status Update: DHS is working to implement 24/7 centralized intake.

13) *Modify policy and training to instruct CSIU intake staff to consider giving more weight to child abuse reports made by mandatory reporters.*

Status Update: We believe it is more important to focus on what information the reporter knows and how their training and experience may make that information more relevant than simply the classification of being a mandatory reporter or not. For example, a nurse may not be a mandatory reporter in a specific case, but they may have training that makes their observations more relevant.

14) *Provide training and resources for intake and field staff impacted by secondary trauma, decision fatigue, and other job related stress.*

Status Update: In addition to our previous response, Polk County DHS has been working with an expert in trauma-informed supervision, which, if successful, DHS will look at expanding across the state.

Conclusion

Our team is dedicated to the families we serve. This was a tragic case. We were all deeply saddened by the loss of both Sabrina and Natalie. We are committed to learning from these tragedies so we can improve the safety net DHS provides for Iowa's children. The Department continues to take action so that we improve the way we support Iowa families.

The Department is grateful to the Ombudsman for their insightful recommendations and looks forward to continuing to work together to ensure the safety of all of Iowa's children.

Mid-Iowa Response

FM BROWN
LAW FIRM

F. MONTGOMERY BROWN
hskrfan@fmbrownlaw.com

July 30, 2020

Kristie Hirschman
Office of Ombudsman
Ola Babcock Miller Building
1112 East Grand Avenue
Des Moines, Iowa 50319

RE: Ombudsman's Investigation in the Death of Sabrina Ray - "Misplaced Trust: An Investigation of the Death of Sabrina Ray"

Dear Ms. Hirschman:

On behalf of Mid-Iowa Family Therapy Clinic (known as Mid-Iowa or MIFTC), I am authorized to respond to the Investigative Report of the Office of Ombudsman (herein after "Report") referred to above and dated May 26, 2020. MIFTC thanks you for providing opportunity to respond to the Report by August 3, 2020. MIFTC responds with the following objections, requests for amendments and additions:

RECOMMENDATION AS TO MID-IOWA (PAGE 67)

The Office of Ombudsman recommends that MIFTC "Review its practice and policy that requires consultation between FSRP services workers and supervisors to ensure non-interference with reporting requirement, consistent with Iowa Code Section 232.70." As set forth in attached MIFTC Exhibit A, at all times material to the Report, MIFTC had in effect, adopted, followed and disseminated to FSRP workers written policies and procedures notifying MIFTC of their obligations to report suspected child abuse in pursuant to Iowa Code Section 232.70. The MIFTC "REPORTING ABUSE" written policies in various forms existed from at least 2010 through the present. All MIFTC employees, including Shelby Messersmith completed during the course of their employment MIFTC Policy and Procedures Training that included knowledge of the employee's responsibilities and duties with respect to reporting suspected child abuse. A copy of certificate of training for Shelby Messersmith is attached hereto and incorporated fully by reference as Exhibit B.

1001 Office Park Road, Suite 108, West Des Moines, IA 50265
Telephone: 515.225.0101 Facsimile: 515.225.3737

MIFTC's written "REPORTING ABUSE" policies in effect at all time material to the matters in the Ombudsman's Investigation in the Death of Sabrina Ray - "Misplaced Trust: An Investigation of the Death of Sabrina Ray". At no time did MIFTC require, mandate or suggest that any MIFTC employee including FSRP workers obtain supervisor permission to report suspected child abuse. MIFTC had no ongoing "practice and policy" that required advance permission or "consultation" between FSRP workers and supervisors prior to reporting suspected child abuse. Accordingly, MIFTC objects to the recommendation set forth on Page 67 as an erroneous finding of fact.

Moreover, at all times material to the Report and since at least 2010, MIFTC had implemented a Risk Management and Quality Assurance Team (QA) with associated policies and protocols of which all employees, including Shelby Messersmith were trained to follow. A copy of the QA written policy is attached hereto as Exhibit C and incorporated fully by reference. The QA Team was designed, in part, to review the conditions and treatment of children and families to which MIFTC provided services. Such review would have included evaluation of reports of suspected child abuse made to DHS by MIFTC employees. Had Shelby Messersmith complied with the existing policies and procedures of MIFTC, Ms. Messersmith would have reported in writing to MIFTC that she had made report(s) of suspected child abuse in the Ray family to MIFTC. Second, MIFTC would have then been in a position via the QA Team to evaluate and assess a particular family, including the Ray family for concerning patterns. The Report should be amended to so indicate.

In addition the Report on Page 66 contains a blocked summary stating: "If it results in a report being suppressed, we firmly believe that Mid-Iowa's practice of requiring FSRP workers to confer with a supervisor prior to making a child-abuse report violates the law." Once again, MIFTC denies the existence of such "practice" and no evidence is contained in the support to support such inference, finding of fact or conclusion of fact and law. In fact, the Report details at least seven instances in which Shelby Messersmith and another unnamed MIFTC employee (acting as a permissive reporter as discussed below), did make a suspected child abuse report to DHS in accordance with MIFTC's policies and without interference or suppression. Accordingly, MIFTC objects to the blocked summary on page 66 quoted above.

OBJECTIONS TO FINDINGS OF FACT

The Report fails to indicate and omits the fact that MIFTC's last date of service to any child associated with the Rays occurred in July of 2014. After that date MIFTC had no involvement with the Rays in any professional capacity. MIFTC requests that the Report so indicate that MIFTC had no involvement with the Ray family or children in their care and custody after July of 2014. The report should be amended to so indicate.

With respect to the "September 22, 2013 Daycare Licensing Complaint" matters referenced on Page 20 of the Report, the Report fails to indicate that the complaint or report made by the MIFTC employee was made by that employee in her private capacity as a so-called "permissive reporter" or permissive report. The Report should be amended to so indicate.

The Report fails to indicate that Shelby Messersmith did not provide MIFTC with a copy of any suspected child abuse report she submitted to DHS during any period of her involvement with the Ray family which concluded in July of 2014. The Report should be amended to so indicate.

While the Notification of The Child Abuse Assessment would have been sent to Shelby Messersmith, it was Ms. Messersmith's responsibility to follow policy and procedures with regards to submitting this notification to her supervisor. The supervisor would have sent this document electronically to the Quality Assurance Director. There is no evidence that MIFTC received the "Notification of The Child Abuse Assessment" regarding the Rays submitted by Shelby Messersmith or any other employee or person. The Report should be amended to so indicate.

With respect to the findings of fact contained on Pages 57-66 under the headings "FSRP services and interference with child abuse report" and "Interference with making a child abuse report", the Report minimizes the context of the controversy between Shelby Messersmith and Susan Smalley. The complete context necessarily includes the legitimate concern that Ms. Messersmith was purportedly communicating matters to the "mother's attorney" outside the appropriate channels of communication and privileges to release information.

Lastly, as stated above to the extent that the Report finds that Shelby Messersmith allegedly encountered resistance to reporting suspected child abuse or raising concerns about possible abuse in the Ray home, any such resistance was contrary to the established written policies of MIFTC. The Report should be amended to so indicate.

On behalf of MIFTC please include this response to the Final Report.

Sincerely,

F. Montgomery Brown

Attorney for MIFTC

REPORTING ABUSE

The Mid-Iowa Family Therapy Clinic, Inc. and the Institute for Therapy & Psychological Solutions, LLC., will identify and notify employees who are mandatory child abuse and/or dependent adult abuse reporters. Each person identified shall be notified of the person's status as a mandatory reporter prior to having contact with any client.

To report abuse, call 1-800-362-2178. This number is available 24 hours a day, 7 days a week. According to Iowa Code section 232.70, if you are a mandatory reporter of child abuse and you suspect a child has been abused, you need to report it to the Department of Human Services. The law requires you to report suspected child abuse to DHS orally within 24 hours of becoming aware of the situation.

You must also make a report in writing within 48 hours after your oral report. A Report of Suspected Child Abuse form must be completed and faxed to 515-564-4011 or mailed to PO Box 4826, Des Moines, IA, 50309.

MIFTC/ITPS requires that you also contact your supervisor and provide a copy of the written report to be forwarded to the QA/Compliance Officer.

The employer or supervisor of a person who is a mandatory or permissive reporter shall not apply a policy, work rule, or other requirement that interferes with the person making a report of child abuse. All employees are obligated to report any act that is suspicious. It is not the employee's responsibility to investigate or prove whether a client has been abused or treated inappropriately.

All employees will attend Mandatory Child Abuse Reporter Training and Mandatory Reporter-Dependent Adult Abuse Training or provide proof of certification within 30 days of employment. Updated training will take place every five years.

All employees will be trained regarding any changes to child abuse law within 30 days of the law going into effect

EXHIBIT
A

REPORTING ABUSE

The agency will identify and notify employees who are mandatory child abuse and/or dependent adult abuse reporters. Each person identified shall be notified of the person's status as a mandatory reporter prior to having contact with any client.

To report abuse, call 1-800-362-2178. This number is available 24 hours a day, 7 days a week. According to Iowa Code section 232.70, if you are a mandatory reporter of child abuse and you suspect a child has been abused, you need to report it to the Department of Human Services. The law requires you to report suspected child abuse to DHS orally within 24 hours of becoming aware of the situation.

You must also make a report in writing within 48 hours after your oral report. A Report of Suspected Child Abuse form must be completed and faxed to 515-564-4011 or mailed to PO Box 4826, Des Moines, IA, 50309.

The agency requires that you also contact your supervisor by emailing the Report of Suspected Child Abuse (ClientLastName_FirstName_RSCA_MonYEAR). Your supervisor will upload the RSCA to SharePoint drop off.

Staff should receive a Notice of Child Abuse Assessment from DHS (LastName_FirstName_NCAA_MonYEAR). Upon receipt, staff will scan and email to their supervisor. Supervisors will upload NCAA to SharePoint drop off. If the report is accepted by DHS, as documented on the NCAA, staff should receive a Notice of Intake Decision from DHS (LastName_FirstName_NID_MonYEAR). Upon receipt, staff will scan and email to their supervisor. Supervisors will upload NID to SharePoint drop off.

QA/Compliance staff will monitor these forms and will email staff for a Child Abuse Report Follow-Up (LastName_FirstName_CARFU_MonYEAR) for the following circumstances:

1. If we make a report and we have not received a NCAA from DHS after 30 days.
2. If we get a NCAA, but do not receive a NID after 45 days of receiving the NCAA.

The agency directors or the supervisor of a person who is a mandatory or permissive reporter shall not apply a policy, work rule, or other requirement that interferes with the person making a report of child abuse. All employees are obligated to report any act that is suspicious. It is not the employee's responsibility to investigate or prove whether a client has been abused or treated inappropriately. These steps are to ensure the agency and its employees' actions do not impede the DHS/DIA investigation.

All employees will attend Mandatory Child Abuse Reporter Training and Mandatory Reporter-Dependent Adult Abuse Training or provide proof of certification within 30 days of employment. Updated training will take place every five years.

All employees will be trained regarding any changes to child abuse law within 30 days of the law going into effect.

Sanctions for Failure to Report Child Abuse

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

Sanctions for Reporting False Information

The act of reporting false information regarding an alleged act of child abuse to DHS or causing false information to be reported, knowing that the information is false or that the act did not occur, is classified as simple misdemeanor under Iowa Code section 232.75, subsection 3.

REPORTING ABUSE

The Institute for Therapy & Psychological Solutions, LLC., will identify and notify employees who are mandatory child abuse and/or dependent adult abuse reporters. Each person identified shall be notified of the person's status as a mandatory reporter prior to having contact with any client.

To report abuse, call 1-800-362-2178. This number is available 24 hours a day, 7 days a week. According to Iowa Code section 232.70, if you are a mandatory reporter of child abuse and you suspect a child has been abused, you need to report it to the Department of Human Services. The law requires you to report suspected child abuse to DHS orally within 24 hours of becoming aware of the situation.

You must also make a report in writing within 48 hours after your oral report. A Report of Suspected Child Abuse form must be completed and faxed to 515-564-4011 or mailed to PO Box 4826, Des Moines, IA, 50309.

ITPS requires that you also contact your supervisor by emailing the Report of Suspected Child Abuse (ClientLastName_FirstName_RSCA_MonYEAR). Your supervisor will upload the RSCA to SharePoint drop off.

Staff should receive a Notice of Child Abuse Assessment from DHS (LastName_FirstName_NCAA_MonYEAR). Upon receipt, staff will scan and email to their supervisor. Supervisors will upload NCAA to SharePoint drop off. If the report is accepted by DHS, as documented on the NCAA, staff should receive a Notice of Intake Decision from DHS (LastName_FirstName_NID_MonYEAR). Upon receipt, staff will scan and email to their supervisor. Supervisors will upload NID to SharePoint drop off.

QA/Compliance staff will monitor these forms and will email staff for a Child Abuse Report Follow-Up (LastName_FirstName_CARFU_MonYEAR) for the following circumstances:

1. If we make a report and we have not received a NCAA from DHS after 30 days.
2. If we get a NCAA, but do not receive a NID after 45 days of receiving the NCAA.

ITPS administrators or the supervisor of a person who is a mandatory or permissive reporter shall not apply a policy, work rule, or other requirement that interferes with the person making a report of child abuse. All employees are obligated to report any act that is suspicious. It is not the employee's responsibility to investigate or prove whether a client has been abused or treated inappropriately. These steps are to ensure ITPS and its employees' actions do not impede the DHS/DIA investigation.

All employees will attend Mandatory Child Abuse Reporter Training and Mandatory Reporter-Dependent Adult Abuse Training or provide proof of certification within 30 days of employment. Updated training will take place every five years.

All employees will be trained regarding any changes to child abuse law within 30 days of the law going into effect.

Sanctions for Failure to Report Child Abuse
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Sanctions for Reporting False Information
The act of reporting false information regarding an alleged act of child abuse to DHS or causing false information to be reported, knowing that the information is false or that the act did not occur, is classified as simple misdemeanor under Iowa Code section 232.75, subsection 3.

This is to certify that

Shelby Messersmith

has successfully completed

MIFTC-Policy and Procedures Manual-Jan2013

Completed on: 9/8/2013 Credit Hours: 1.00

EXHIBIT

B

INTERNAL QUALITY MONITORING

The performance quality improvement monitoring is the responsibility of all personnel with oversight completed by the Risk Management and Quality Assurance Team. The purpose of the team is to identify overall organization issues, implement solutions that improve overall productivity, and promote accessible, effective services in all sites across the state.

The Risk Management and Quality Assurance Team is comprised of the following:

Team members:

CEO
QA/Compliance Officer
Representative of Family Preservation and Stabilization Services
Representative of Mental Health Services
Clinical Director

Procedures:

The team meets quality and reviews and assesses the performance activities of the agencies. The following outlines the activities, method and timelines of monitoring and reporting, and the identification of barriers that need addressed in order to promote improved productivity, service delivery and overall operations of the agencies.

1. Every quarter review practices that involve risk or limits freedom of choice, including:
   a. Review where an individual was determined to be a danger to self or others.
2. Reviews client and personnel grievances, incidents, or accidents involving clients or personnel.
3. Reviews service outcome data per service area and reports the outcomes to the team on a quarterly basis.
4. Reviews quarterly consumer satisfaction and annual stakeholder surveys and addresses issues and concerns.
5. Reviews policies and/or operational procedures, personnel assignments, personnel training, contracts, and programs.
6. Reviews quarterly the quality of the service environments.
7. Annually, reviews risk management assessments of overall risk to the agency including: Review of research involving program participants, and reviews compliance with legal requirements including DHS contracting, insurance contracting, child placing agency license, and mandatory reporting laws.
8. Reviews at least annually insurance coverage for the agencies.
9. Quarterly review of employment patterns, including new hires, terminations, and resignations. Review of Exit Questionnaires. Annual review of Personnel Records as completed by the Human Resource Manager.
10. Review of Adult Services Behavior Intervention Plans and Rights Restrictions.
11. Review of Corrective Action from previous RM/QA meeting to ensure follow through and accountability.
12. The team meets quarterly and completes the Quarterly Review Report in reporting their activities.
13. Periodically the Quality Review Report is shared with stakeholders, CEO and the management/supervisory personnel for their feedback. This mechanism is designed to enhance the PQI process and facilitate change where indicated

EXHIBIT
C

EMERGENCY RESPONSE (ASE 6 & 7)

Policy:

Children, adolescents, and families who are clients have the right to receive services in a safe environment that can manage injuries, accidents, illnesses, and emergency situations. Each site maintains its own evacuation policy for fire, tornado, and natural disasters.

It is the policy of Mid-Iowa Family Therapy Clinic, Inc., and Institute for Therapy & Psychological Solutions, LLC, to protect personnel and persons served from physical harm, harassment, and intimidation. To provide a safe environment, this organization is committed to establishing an effective emergency plan.

Parents/legal guardians will be notified within 72 hours of an incident.

Procedure:

All staff will be trained on how to respond to the emergencies below by reviewing these policies and procedures during their orientation and by asking questions regarding the information as needed. (7.04) Staff will document major and all other incidents.

For consumers receiving Home and Community Based Habilitation Services or Children's Mental Health Waiver Services, major incidents must be reported to the member's DHS Case Manager. A Major incident means an occurrence involving a member during a services provision that results in a physical injury to or by the member that requires a physician treatment or admission to a hospital. These may include the following events:

1. *Incident resulting in the death of any person,*
2. *Requires emergency mental health treatment for the member,*
3. *Requires the intervention of law enforcement,*
4. *Requires a report of child abuse pursuant to Iowa Code,*
5. *Requires a report of dependent adult abuse pursuant to Iowa Code,*
6. *Constitute a prescription medication error or a pattern of medication errors that lead to any outcomes stated above.*

1. *Involves a member's location being unknown by provider staff who are assigned protective oversight.*

Following a Major incident, the following needs to occur:

1. Notify a supervisor, the member's case manager and the member's legal guardian by the end of the next calendar day after the incident. The staff may accomplish this by faxing or mailing the **Critical Incident Report Form 470-4698** to:

   Iowa Medicaid Critical Incident Report
   Provider Correspondence
   P.O. Box 36450
   Des Moines, Iowa 50315
   FAX #: 515-725-1360

   Critical Incident Report 470-4698 Form Instructions and Definitions can be found at:
   http://www.ime.state.ia.us/docs/CriticalIncidentReportUserGuide08282009.pdf

   Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The provider shall track incident data and analyze trends to assess the health and safety of members served and determines if changes need to be made to for service implementation or if staff training is needed to reduced the number of incidents.
2. Send a copy to the QA/Compliance Officer for review by the Risk Management & Quality Assurance Team.
3. File original in the Client Record.

For all other incidents:

1. Complete a MIFTC & ITPS Incident Report.
2. Forward the report to the supervisor or designee within 72 hours of the incident and the QA/Compliance Officer.
3. File original in the Case Record.

Workplace emergency:
In the case of an emergency, the Site Administrator or designee will ensure the following:

- Report emergencies to local fire and police departments.
- Warn personnel about the emergency.
- Conduct an orderly, efficient workplace evacuation.
- Assist persons with mobility challenges or limited English-speaking skills during an evacuation.
- Shut down critical equipment, operate fire extinguishers, and perform other essential services during an evacuation.
- Account for personnel and persons served at a designated safe area after an evacuation.
- Perform rescue and first aid activities that may be necessary during an emergency.
- Contact the CEO for further instructions and possible establishment of a temporary work site with emergency telephone, Internet and facsimile use, and procedures for handling the media. (7.01 & 7.03)

First Aid:
MIFTC & ITPS are prepared to deal effectively with accidents and illnesses by having first aid kits readily available at each site and in each agency vehicle. Each kit will contain a list of the required supplies. Each Site Administrator or designee will complete a First Aid Contents Check monthly and forward to the assigned QA/Compliance staff.

For accidents and medical emergencies, staff shall administer First Aid as appropriate and immediately contact 911 for assistance.

All incidents requiring first aid are to be reported on an Incident Report form. If the person is a minor, the parent/guardian is informed immediately and receives a copy of the Incident Report form.

Accidents/Injuries:
Only significant accidents/injuries need to be reported on an Incident Report. In general, if the accident/injury left a prominent mark and/or required first aid or medical attention then an Incident Report should be completed. In all other cases (i.e. minor scrapes, scratches, bumps) if the client is a minor, the incident should be verbally reported to the parent/guardian, but an Incident Report is not necessary. In cases where there is any question as to the severity of the accident/injury, it is recommended that an Incident Report be completed. (7.02)

Poison Control:
In the case of a person coming in contact with poison, staff will be expected to follow first aid procedures and refer to the Poison Control Fact Sheet that can be found posted by the first aid kit and follow the instructions given according to the type of contact.

If the person that has come in contact with poison is a minor, the parents or guardians will be informed immediately and an Incident Report form will be completed within 24 hours.

Fire:
Any staff aware of a fire should immediately sound the fire alarm to insure that all staff, clients, and visitors are evacuated from the building. Each office will maintain specific fire evacuation plans. Plans are to be reviewed yearly with staff. Each site is required to run a fire drill annually. These drills are to be documented on the Drills form and turned in to the QA/Compliance Officer and reviewed annually by the Risk Management & Quality Assurance Team. (6.02)

Natural disasters (i.e.; flood, tornado, blizzard):
Each office shall maintain specific safety plans for their buildings. Emergency kits containing the minimum of a flashlight, radio, and batteries shall be maintained in each site. Natural disaster drills will occur annually for each site. Site supervisors and/or administrators are responsible for closure of the office in the event of a natural disaster. These

drills are to be documented on the Drills form and are turned to the QA/Compliance Officer and reviewed annually by Risk Management and Quality Assurance Team.

Threat of harm/ physical violence:
Individual directed threats of violence or harm are communications that create fear of physical harm to a specific individual or individuals, communicated directly or indirectly by any means.

Physical harm or violence is any behavior performed by anyone that causes fear, panic, injury, or death to another person or damage of property. Building directed threats of violence or harm are direct or indirect communications by any means of the intent to cause damage to an agency building or agency property (e.g. bomb threats), or to harm clients, employees, volunteers, or visitors.

In the case that a threat or physical harm is carried out toward another person, MIFTC and ITPS may be required for personnel to terminate services, inform law enforcement, and/or press charges.

The incident will be documented on an Incident Report form within 24 hours. And in the case of a minor, parents or guardians will be informed in a timely manner.

Parents or guardians of the victim of the threat or violent act will also be informed and may be given the option to press charges.

Elopement Procedures:
During the course of treatment if a client that is a minor, attempts to run away or leave the building, staff will make the determination according to the risk of harm, age, cognitive/developmental functioning, if they will attempt to manually restrain the client to keep them from leaving the building. In the case that a client does leave, staff will immediately inform law enforcement and request an attempt to locate. Staff will then inform parents/guardians. An incident report will be completed within 24 hours.

Upon returning to treatment, the incident may be processed with the client, staff, Program Supervisor, Site Administrator or designee, parents/guardians and caseworker if necessary.

In the case that a client is lost (i.e. is not available for transport), staff will immediately attempt to contact parents/guardians or the emergency contact to find out if they are aware of the client's whereabouts. If staff are informed by persons contacted of the client's whereabouts, staff **do not** need to complete an incident report. If staff are unable to contact any of the above, staff will immediately inform law enforcement and request an attempt to locate. If the persons contacted are also not aware of the client's whereabouts, it will be the parents/guardians decision if law enforcement need to be contacted. An incident report will be completed within 24 hours.

All incidents must be reported on an Incident Report form and turned into the Site Administrator or designee. Quarterly, the Site Administrator or designee will ensure that all Incident Reports are forwarded to the QA/Compliance Officer to be reviewed by the Risk Management and Quality Assurance Team.

INTERNAL QUALITY MONITORING & FEEDBACK MECHANISMS

Procedures:

The Quality Review Report is a form created by the Risk Management & Quality Assurance Team.

The Risk Management and Quality Assurance Team spend time at least quarterly conducting PQI activities. PQI activities include examination of outreach, intake, assessment, service delivery process, identification of barriers and opportunities to service any groups within its defined population, human resource deployment training, supervision, use of restrictive behavior management interventions, all cases where an individual was determined to be a danger to themselves or others; research involving participants, legal requirements including licensing and mandatory reporting laws, grievances, incidents, accidents of persons served, and/or personnel; administration, dispensing of medications, review site environment checklist, and external review processes; and reports on those activities using the Quality Report Review. The Risk Management and Quality Assurance Teams will use a variety of ways in collecting data for its review. Methods used, include but are not limited to, incident reports, grievances, environmental checklist, employee training checklist, orientation checklist, client satisfaction survey data, budget variance report, supervisor quarterly report, summary form, and external review processes.

The Risk Management and Quality Assurance Team is responsible for collecting all Quality Review Reports and provides information per program on the agency's progress toward full implementation of the PQI Plan. Information is shared with staff, funding entities, clients, and others that maybe interested in the agency's performance.

Mark Chappelle Response

2 August 2020

State of Iowa

Office of Ombudsman

Ola Babcock Miller Buidling

1112 East Grand Avenue

Des Moines, Iowa 50319

In re: The death of Sabrina Ray – response by C. Mark Chappelle

I write in reference to two issues contained in the report authored by the Office of the Ombudsman. First, there is the issue of the meeting between myself, Susan Smalley of Mid Iowa Family Therapy, and Shelby Messersmith of Mid Iowa Family Therapy. The Ombudsman's Office apparently seized on a comment I made at the outset of this incident. I recall the incident of Shelby talking with the attorney in the sense it was brought to my attention with a good deal of upset. I do not recall whether it was brought to my attention by Marcia Hoffman, a social worker under my supervision, or it was relayed to me by Susan Smalley. I made the comment that I did not want to "publicly flog" Shelby and that was quite true. While I am at times given to hyperbole, I did always strive to inject a great measure of reason, understanding, and compassion into the interactions I had with colleagues however contentious the subject matter might have been. I did not want Shelby to be dissuaded in making reports, however those reports might be handled, or in the estimation of those who have investigated this most regrettable situation, mishandled by DHS. I held no malice nor ill-will towards Shelby in this circumstance, but I was concerned the manner in which she was reporting her concerns fell outside what Iowa Code provides in making such reports, and was going to cause issues for all those involved. The only avenue for mandatory reporters in this state to make reports is through DHS. Reasonable people can and do disagree regarding how those reports were handled by DHS at intake and by those charged with the responsibility to resolve said reports, but the fact remains the report should have come through DHS and not the attorney. I think this was a bit more than what is characterized as a "breach of etiquette" by the Office of the Ombudsman, though certainly understandable given Shelby's concerns about the Rays and conditions in the home. Shelby was certainly concerned and courageous in speaking out. Ultimately all of us at DHS involved in this case failed to a greater or lesser degree in the death of Sabrina Ray.

I entered the meeting with Shelby with the intent of talking with her about the importance of making reports to DHS as the Iowa Code provides. There was most certainly no intent to relay to her the idea she should "shut up and do your job" nor to "privately flog" her for her actions. I am also most acutely aware of the difference between intent and effect in communication. Shelby reports feeling "defeated" following this meeting. For that effect, I am deeply saddened. This was not at all what I intended, though that is how Shelby left the meeting. Though it is too little and much too late, I believe I owe her an apology.

The second issue arises in how the Ombudsman's Office appears to assign responsibility to me alone in the decision to place the Ray's foster care license on "Hold". Though the report does describe others being involved in discussions concerning this matter, I believe I am left "holding the bag" as it were in this matter. I was not empowered to make such a decision alone and had no resource nor facility to enact or enforce such a decision. The discussion and decision, was shared by line supervisors who oversaw the foster care service and with my supervisor and the SAM at the time. I would like the report to more clearly state that circumstance.

C. Mark Chappelle

C. Mark Chappelle

Ombudsman's Comments

> Ultimately all of us at DHS involved in this case failed to a greater or lesser degree in the death of Sabrina Ray.
>
> *Mark Chappelle's written response to the Ombudsman's report*

Iowa Code section 2C.15 requires the Ombudsman to consult with agencies and individuals that are criticized in an investigative report, and to attach their unedited written replies to the report.

DHS; eleven current and former DHS employees; and Mid-Iowa Family Therapy Clinic (Mid-Iowa) were offered the opportunity to reply to the report. The Ombudsman received replies from DHS Director Kelly Garcia, former DHS employee Mark Chappelle, and Mid-Iowa. The Ombudsman will address each response individually.

DHS

DHS provided a prompt response to our recommendations, affirmatively accepting 10 of my 13 recommendations, including my recommendations for DHS to review the standards necessary to suspend a foster care license, conduct training and explore engaging medical professionals to identify malnourishment, and to improve daycare licensing.

I would, however, like to comment on several of DHS's responses to my recommendations.

Record Retention Policy

DHS raised policy concerns with the first recommendation in the report, which involved increasing the retention period for child abuse intakes. DHS provided the following response to our recommendation:

> This recommendation is consistent with the recommendation in the Natalie Finn report. The balancing of the proper length of time to maintain child abuse information is a valid public policy question for consideration by elected officials. The Department relies on intake and assessment information to protect children. In 2010, the Legislature revised Iowa Administrative Code to change the retention of rejected intakes from six months to three years to provide the Department with more historical information in case of future abuse referrals. The Legislature subsequently established a group to make recommendations for changes in the retention of founded abuse cases. In 2013, legislation was passed which allows for a person's name to be removed from the registry after five years (rather than ten years) if they were placed on the registry as a result of physical abuse, denial of critical care, or presence of illegal drugs in a child's system and the child abuse did not result in the child's death or serious injury and there was no subsequent abuse within that five year period.

DHS's response to this recommendation is nearly identical to the agency's response to the same recommendation I made in the Finn report. I will again emphasize the comments I made to DHS previously:

> First, my recommendation that founded child abuse assessment records be maintained indefinitely is an entirely separate matter from the length of time a person's name remains on the child abuse registry. Secondly, DHS's response implies it has no role to play in this issue. What the response fails to acknowledge is that DHS can propose changes to statute and administrative rules for consideration by the Legislature.
>
> I strongly believe this recommendation is important to protecting children. Identifying historical patterns of similar allegations and abuse was critical in this case. For this reason, I intend to work with the Legislature to increase the retention period for child abuse intakes and assessments.

Both the Finn and Ray reports have demonstrated a need for DHS to reassess the need to extend the record-retention timeline. Legislative consideration is necessary in light of the impact it has on reviewing and assessing child welfare cases.

Foster Care Hold

Our second recommendation called for removal of children as soon as possible when DHS placed a foster family's license on "hold" status. DHS did not believe automatic removal was always the right answer:

> The Department agrees with the recommendation to create a protocol to guide decision-making around placing a foster home on hold. Placing a home on hold allows the Department to gather additional information with which to make a formal decision regarding continued licensure. However, automatically removing children currently placed in a home on "hold" status and into another home is traumatizing, and requires a thoughtful approach. It may be that removing the children is not always the right answer. Decision documents help guide critical thinking in decision-making and DHS will develop a guidance tool for consistency.

I understand and appreciate that removing children from a home could be traumatizing. My recommendation is that foster care children be removed as soon as possible once a foster family's license is placed on "hold" status. Taking into consideration finding a new placement option, and making that transition, may take time. However, if a home is determined to not be appropriate for *future* child placements – such as the reason for the "hold" – I do not understand the logic that the *current foster* children could safely remain in the home.

Internal Review Process

Recommendation #13 in the report called for a protocol in policy that would require DHS conduct an internal review and a written report by a designated team when DHS believes the death of a child was the result of abuse.

My recommendation included specific examples that would trigger mandatory completion of an internal review and written report in instances when DHS reasonably believes the death of a

child under the age of 18 was the result of child abuse. DHS's response acknowledges that internal reviews occur to identify gaps and areas of improvement; but its response does not affirmatively accept this recommendation. I strongly believe a policy needs to be in place to ensure that internal reviews *must* occur following certain events. As stated in the report, DHS did not conduct an internal investigation or review following the death of Sabrina Ray. Such a review would be required under the guidelines of this recommendation.

I want to also acknowledge that DHS's response included updates on the implementation of the recommendations I made in the Natalie Finn report. I thank Director Garcia and her staff for these updates and their cooperation with the this investigation. I look forward to continuing to working collaboratively to make system improvements to better protect children in Iowa.

MID-IOWA FAMILY THERAPY CLINIC

Mid-Iowa Family Therapy Clinic (Mid-Iowa) responded to our report with several objections and requests for amendments and additions.

Mid-Iowa's response indicates that at no time were Family, Safety, Risk, and Permanency (FSRP) workers required to receive advance permission, or engage in consultation with supervisors, before reporting suspected child abuse. This statement is contrary to the information that was provided to our office by Mid-Iowa's Program Director of FSRP, Susan Smalley, and former Mid-Iowa FSRP worker Shelby Messersmith.

In her testimony to our office, Messersmith reported that she had to correspond with her supervisor (Smalley) before making a report to DHS "to make sure the case is understood and worthy of reporting." Likewise, Smalley told us: "That is our practice, to make sure staff are being in touch with their supervisors to discuss the situation – so we are aware – supervisors need to be aware what is going on with the family." Smalley went on to describe the purpose of the consultation as "it's a discussion based on the information that our staff have, and together making sure they are following the guidelines – as a mandatory reporter, does it meet those expectations to be considered suspected child abuse."

Although Mid-Iowa may not have a written policy in place to require consultation between FSRP workers and their supervisor before a child abuse report is made, this was clearly the practice in 2014.

Mid-Iowa also argued that a number of sections of the report should be amended. After careful consideration of Mid-Iowa's requests, we have chosen to not make any changes. I will address the requests individually.

First, Mid-Iowa requested that the report be modified to indicate that Messersmith did not comply with the requirement that she report to Mid-Iowa, in writing, the child abuse reports she made to DHS. Mid-Iowa explains that the company utilizes a Risk Management and Quality Assurance Team (QA Team) to "review the conditions and treatment of children and families to which MIFTC provided services." The policy articulates that "MIFTC/ITPS requires that you also contact your supervisor and provide a copy of the written report to be forwarded to the QA/Compliance Officer." Mid-Iowa contends that Messersmith's failure to provide her

supervisor with copies of the child abuse reports hindered the QA Team from evaluating the Ray family.

Our office received an email exchange dated April 24, 2014, in which Messersmith informed Smalley that she had made a report of child abuse to DHS that day. She added that the DHS ongoing worker was "not thrilled" that she had done so. Mid-Iowa provided no information to suggest that Smalley, as her supervisor, instructed Messersmith to submit a written report for the QA Team, or that her failure to do so would result in a violation of Mid-Iowa's policy.

Mid-Iowa's internal policies notwithstanding, our report found that Messersmith took reasonable steps to raise concerns that the Rays were abusing children. However, Mid-Iowa's response would seem to suggest that the only thing preventing the company from identifying the patterns of abuse was Messersmith's failure to submit a written report to her supervisor. I am not persuaded by their arguments, so I have chosen not to amend the report. Further, from the information shared with our office, other members of Mid-Iowa's management team were aware of Messersmith's concerns with the Rays, including CEO Christine Secrist and Family Preservation and Stabilization Services Director Lori Mozena (See Pages 62 and 92).

Second, Mid-Iowa states that our report "fails to indicate and omits the fact the MIFTC's last date of service to any child associated with the Rays occurred in July of 2014." Mid-Iowa requested that our report be amended to provide this information.

Our report twice states that the Rays' last foster care placement ended on July 28, 2014. Specifically, on Page 65, the report says: "The children were ultimately reunified with the biological mother on July 28, 2014. This was the last time the Rays had foster children placed in the home." Without foster care children in the home, Mid-Iowa had no role with the family. We believe this conclusion is readily apparent in the report.

The fact that there was no involvement with the family for almost three years prior to Sabrina's death in no way impacts our criticism of Mid-Iowa. I did not find that this change would significantly impact the pertinent facts or findings of the report, so I have chosen not to amend the report.

Third, Mid-Iowa requests that the report be amended to indicate that a daycare licensing complaint made on September 22, 2013, was done by a Mid-Iowa employee acting in a "private capacity as a so-called 'permissive reporter.'" This information does not significantly impact the pertinent facts or findings of the report, so I have chosen not to amend the report.

Lastly, Mid-Iowa requests that the report be amended to indicate that, to the extent we found Messersmith received resistance to reporting child abuse and raising concerns about the Ray family, such resistance was contrary to Mid-Iowa policies. Regardless of whether the resistance was contrary to policy, we found that it did occur, so I have chosen not to amend the report.

I would like to thank Mid-Iowa for providing a response, and for cooperating with our investigation.

MARK CHAPPELLE

Mark Chappelle provided a response to our report and identified two issues. Before I address Chappelle's concerns, I want to thank him for not only reviewing the report and providing his response, but also for providing great insight and candor during our investigation. We appreciate his cooperation.

Chappelle explains his position on Shelby Messersmith approaching a parent's attorney with her concern about a foster care child placed with Marc and Misty Ray. Chappelle asserts that he "did not want Shelby to be dissuaded in making reports," but "the fact remains the report should have come through DHS and not the attorney." He states it is a "bit more than what is characterized as a 'breach of etiquette'" in the report.

It is not entirely clear whether the issues Messersmith raised to the biological mother's attorney were the same issues that she had made a child abuse report about (April 24, 2014, rejected intake), or those which she raised to DHS ongoing worker Marcia Hoffman. However, we agree with Chappelle that an FSRP worker should not raise concerns with a parent's attorney *rather than* going to DHS.

That said, Messersmith explained to us that she felt her concerns were not being taken seriously, and we believe she was acting in good faith to ensure the safety of the children when she reported the issues to the mother's attorney.

Chappelle also states that our report assigns him sole responsibility in the decision to place the Rays' foster care license on "hold." He writes that he was not "empowered to make such a decision alone" and that the decision "was shared by line supervisors who oversaw the foster care service and with my supervisor and the SAM at the time." Chappelle requests that our report provide clarification on this.

Page 54 of the report provides information shared by DHS concerning the decision to place the Rays' foster care on "hold" for future placements. The report reflects that a number of individuals participated in a staffing and were involved in the decision, including a foster care licensing worker and supervisor, the ongoing worker and supervisor (Chappelle), and a field worker and supervisor.

Further, we state on Page 55 of the report:

> Regarding DHS's administration's involvement in the decision to place the Rays' license on "hold" for future placements, DHS shared that "licensing staff were directed by SAM[156] Pat Penning that this home was not to be used and would not be used in the future."

As such, we do not feel it is necessary to amend our report to provide any further clarification as to who was involved with the decision to place the Rays' foster care license on "hold."

[156] SAM refers to Service Area Manager.