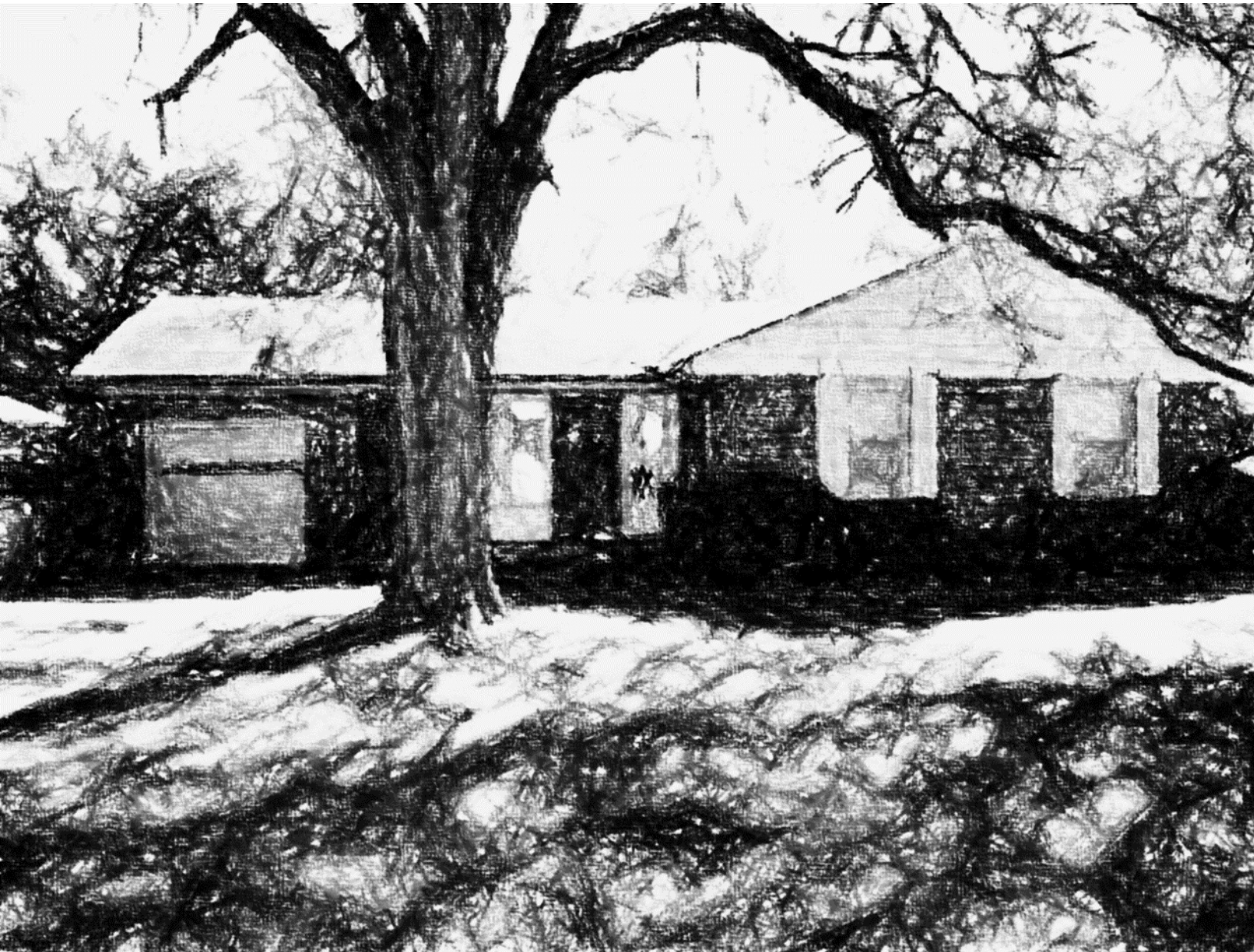


A Tragedy of Errors: **An Investigation of the Death of Natalie Finn**



Iowa Office of Ombudsman

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From the Ombudsman

I think it's unfortunate that things don't generally change within the systems until a tragedy occurs.

Former DHS intake worker

Natalie Finn was just 16 when she died of cardiac arrest on October 25, 2016. After I read an article in The Des Moines Register alleging that DHS had failed to act on a report that Natalie was being starved, I self-initiated an investigation into her death.

At that time, it had been 16 years since the Ombudsman's office had issued a public report critiquing DHS's actions involving the death of a child. Unfortunately, some of the problems we identified in our 2000 report on the death of 2-year-old Shelby Duis were repeated by DHS in Natalie's case: intake reports did not contain some allegations made by reporters, or inadequately described those allegations; child-abuse reports that should have been accepted were rejected; and important collateral witnesses were not identified or contacted.

We also discovered new areas of concern. DHS's record-retention policies have been hindering its workers' ability to identify patterns of abuse. The intake unit has been suffering from insufficient staffing, supervision, and oversight. We found that reports of abuse from experienced mandatory reporters were not given proper weight, and two of their written follow-up reports were not reviewed.

This report details the problems we identified with DHS's child abuse intake and assessment processes in connection with the Finn case and offers 14 recommendations to address these issues.

In addition, this report asks the Iowa Legislature to re-evaluate its expectations of the Child Fatality Review Committee and other existing oversight bodies responsible for reviewing child deaths.

We found no substantive problems with the actions taken by employees of West Des Moines Community Schools, where Natalie attended, or the West Des Moines Police Department.

To its credit, DHS implemented some systemic changes during our investigation. Such quick acknowledgment that improvements were warranted confirms what we saw – that DHS workers are dedicated professionals with a strong work ethic rooted in a desire to serve victims of abuse and their families. So why do problems persist?

A number of the problems can be attributed to a lack of adequate resources. Although DHS received funding for the current fiscal year to hire additional field staff, I believe employees remain overworked, especially those in the intake unit. I am seriously concerned that the recent budget increase is insufficient, especially in light of the increasing numbers of abuse reports and investigations since Natalie's death.

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I also want to thank those individuals who tried to sound the alarm about Natalie's abuse. I empathize with the pain you felt when Natalie died. It became clear during our interviews that the life of every person who made a report to DHS about Natalie has been forever changed. One school employee told us, "I feel like I have a broken heart from the whole situation, and it's very painful to know that despite many people trying, it was ignored, and she ended up losing her life, and just the thought of what she endured is unbearable." A school administrator said Natalie's death had been "the worst thing, the most devastating thing that has happened to me in my whole career."

It saddens me deeply to say that my office is currently investigating the deaths of two other children whose families had contact with DHS. I pledge to the citizens of Iowa that the Ombudsman's office will continue its efforts to identify problems and to make recommendations to protect our children and grandchildren. But my office cannot do it alone. I sincerely appreciate DHS's cooperation with our investigation and I look forward to working with Director Kelly Garcia and her staff to ensure the safety of all of Iowa's children. I will also ask the Legislature to join in these discussions. We must all work collectively and cooperatively to prevent another tragedy.

A handwritten signature in black ink that reads "Kristie Hirschman". The signature is written in a cursive style with a large, sweeping initial 'K'.

Kristie Hirschman
Ombudsman

Executive Summary

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 records involving the Finn family. We are only including, however, information that we believe is necessary to explain the problems we identified.

INTRODUCTION

On October 24, 2016, West Des Moines police officers and medical rescue personnel were called to a single-family home regarding a report of cardiac arrest.¹ Sixteen-year-old Natalie Finn was found unresponsive and not breathing, and she appeared thin and malnourished to the officers.² Natalie was taken by ambulance to Blank Children’s Hospital.³ “She was wearing an adult type diaper and appeared to have been laying on the floor of a bare room in her own waste for some time,” the lead detective wrote in his report.

Natalie was pronounced dead the next day at 1:20 a.m.⁴ Her cause of death was later determined to be emaciation due to denial of critical care.⁵ Natalie was also found to be suffering from dehydration. Her weight upon being admitted to the hospital was 66 pounds; she had weighed 107.2 pounds at a doctor visit on February 22, 2015.⁶

The lead detective also wrote that Natalie’s two biological siblings “were admitted to the hospital because they too were severely underweight and also had bedsores about their bodies.” According to medical testimony at the mother’s trial, Natalie’s two biological siblings⁷ were admitted to the hospital and needed months to recover.⁸

When Natalie died, the Iowa Department of Human Services (DHS) had two open child abuse investigations involving the Finn family. The first had been opened nearly five months before and there had been no meaningful action for more than two months. The second child abuse investigation was opened just a few hours earlier, after one of the police officers at the Finn residence called DHS’s Child Abuse Hotline to report Natalie’s extremely critical condition.

The lead detective and a DHS field worker began interviewing Finn family members, who explained that their adoptive mother, Nicole, would not allow the children to eat unless they asked for food. One of the children testified at the criminal trial that when Nicole ignored their

¹ West Des Moines Police Detective Chris Morgan, *Search Warrant*, November 2, 2016, page 5.

² *Id.*

³ *Id.*

⁴ Frank Garrity, M.D., *Report of Investigation by Medical Examiner*, December 5, 2016.

⁵ *Id.*

⁶ *Id.*

⁷ Hereafter in this Executive Summary, all references to Natalie’s “siblings” are about her two biological siblings, and not any other adoptive siblings in the Finn family, unless stated otherwise. Similarly, all references to “children” are about Natalie and her two biological siblings, unless stated otherwise.

⁸ Lee Rood, *Nicole Finn convicted of murder in daughter’s starvation death*, Des Moines Register, December 14, 2017.

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requests, they just gave up asking. At some point, one of the children put up a sign in the bedroom window that read, “Need food and money.”

Investigators also learned that Natalie and her siblings needed permission from Nicole to leave their bedroom, but they were not allowed to wake her up if she was sleeping, which was often due to her medical issues. Their bedroom door was equipped with an alarm that would go off any time the door was opened. As a result, the children were rarely allowed to leave their room.

After the beds and carpet were removed, the children were left with only a linoleum floor to sleep on with a blanket and pillow.

Joe Finn, the children’s adoptive father and Nicole’s ex-husband, said he had not seen the children in two to three weeks before Natalie’s death, and that was only to take out the beds and carpet from the bedroom.

At some point Natalie stopped eating on her own, though food was offered to her. Natalie first needed help standing up, then she needed help walking. Eventually, Natalie needed help eating. No one could explain why Natalie stopped eating. They said Nicole did not take her to a doctor out of concern she would get in trouble for Natalie’s condition.

Both parents were criminally charged. Nicole was subsequently convicted and received four life sentences. Joe pled guilty and received three 10-year sentences to be served consecutively.

DHS’s investigation concluded with 12 founded child abuse allegations against Nicole and six founded child abuse allegations against Joe. DHS placed all 18 founded allegations on the Child Abuse Registry.

Following an internal investigation, DHS officials fired a field worker and her supervisor for their handling of the investigation that was opened nearly five months before Natalie’s death. DHS management also conducted “coaching and counseling” disciplinary actions with four employees who handled child abuse reports related to the Finn family.

OMBUDSMAN INVESTIGATION AND THE ROLE OF OTHER OVERSIGHT BODIES

The Ombudsman first heard of Natalie Finn on December 8, 2016, through media reports that DHS allegedly failed to investigate reports of a starving child prior to her death. We issued a notice of investigation to DHS that same day.

There were, however, other government bodies – particularly the Child Fatality Review Committee – that could have reviewed DHS’s actions in the case. To avoid duplication of efforts, we needed to determine what specific role our office would have compared to these other oversight agencies.

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.”⁹

In December 2016, an Iowa legislator formally requested that the State Medical Examiner, Dr. Dennis Klein, convene a CFRC to review DHS’s role in Natalie’s death. Dr. Klein subsequently declined the request. Clearly the purpose of a CFRC is to review fatality cases such as that of Natalie Finn. Notably, however, since the legislation was passed in 2000, *the committee has never been convened.*

The other oversight entities we identified 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. This begs the question: What are the Legislature’s expectations of these other 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.

CHILD ABUSE INTAKE AND ASSESSMENT PROCESSES

The Centralized Services Intake Unit (CSIU) accepts child abuse reports Monday through Friday, 8:00 a.m. to 4:30 p.m. Calls outside of those hours are handled through an after-hours on-call system.

When DHS receives a child abuse report, staff conducts an intake to determine if the report should be accepted or rejected. A child abuse report must meet three criteria to be accepted:

1. The alleged victim is a child, defined as any person under the age of eighteen years,¹⁰ and
2. The alleged perpetrator is a caretaker,¹¹ defined as a person responsible for the care of the child, and
3. The alleged incident falls within the statutory definition of child abuse.¹²

When intake staff accepts a child abuse report, it is assigned to a field worker to conduct an assessment. Since 2014, there have been two types of assessments: a child abuse assessment and

⁹ IOWA CODE § 135.43(4).

¹⁰ IOWA CODE § 232.68(1).

¹¹ IOWA ADMIN. CODE r. 441—175.21.

¹² IOWA ADMIN. CODE r. 441—175.24(1).

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a family assessment. The family assessment is only used in “denial of critical care” cases where the child is not in imminent danger. All other allegations are handled as child abuse assessments.

RETENTION OF CHILD ABUSE RECORDS

Prior to March 1, 2010, DHS was only required to keep rejected intakes for six months. After that date, the retention period was expanded to three years.¹³ Keeping rejected intakes allows that information to be considered as part of future intake decisions and assessments.

Accepted intakes are kept based on the finding of the assessment. “Confirmed” and “not confirmed” child abuse assessments are to be retained for five years, or five years from the date of closure of the service record, whichever occurs later.¹⁴ Summaries of “founded” child abuse assessments are kept on the Child Abuse Registry for ten years (or ten years after the most recent confirmed abuse when the same victim or person responsible is placed on the Registry).¹⁵

FOUR CHILD ABUSE REPORTS: 2005-2012

2005/2006 accepted intake and assessment (outcome unknown)

A woman told us that she worked at the Happy Time Daycare in 2005 or 2006 when Natalie, and her siblings – ranging in age from 3 and 5 years old – attended the center. The daycare worker told us that she made a child abuse report after seeing ligature marks on one child’s neck. The child said her mother had caused it. Based on the daycare worker’s description of what occurred next, it appears DHS accepted the report for an assessment. She said a DHS worker came to the daycare and asked questions. According to the daycare worker, when Nicole learned that the woman had made the child abuse report, Nicole pulled her children out of the daycare the next day. The woman did not know what resulted from her abuse report. DHS does not have a record of any such report.

2008 accepted intake and assessment (outcome unknown)

DHS officials told us that an intake was accepted on April 10, 2008, and an assessment was completed on May 8, 2008. Nicole Finn was the alleged perpetrator and the children were identified as alleged victims. At that time, they were 7 years old, 6 years old, and 5 years old, respectively.

DHS officials said that all records connected with this intake and assessment were expunged in May 2013, pursuant to the agency’s record-retention rules. As a result, no other information is available about either the intake or the assessment, including who reported it, the type of abuse that was alleged, and the outcome.

¹³ IOWA ADMIN. CODE r. 441—175.24(4)(c).

¹⁴ IOWA ADMIN. CODE r. 441—175.32(3)(b) and 175.32(4)(b).

¹⁵ DHS, *Notice of Child Abuse Assessment: Founded*, 470-3243 (Rev. 3/17)

2009 child abuse report by Natalie's fourth-grade teacher

A teacher told us that he made a child abuse report in late 2009, when Natalie was in his fourth-grade class. According to the teacher, he reported to DHS that Natalie told him she was confined in a room for several hours every day and she was not allowed to eat during those times. “She had shown marks on her arm that I remember definitely seeing,” the teacher told us. “With the pushing and shoving of not wanting to go into the room.”

The teacher described the marks on Natalie's arm as scratches and red “grabbing marks.” He did not recall receiving any written notice or other communication from DHS in response to his report.¹⁶ He said the DHS employee who took his call indicated his report was not sufficient to warrant an assessment. DHS does not have a record of any such intake.

2012 accepted intake and assessment (not confirmed)

DHS received a child abuse report about one of Natalie's siblings from a nurse at Hillside Elementary School in February 2012. According to the intake document, the reporter alleged that Nicole had pulled the child's hair and left scratch marks and some light bruising.

The intake was accepted for an assessment. According to the Child Protective Assessment Summary, the incident occurred shortly after Nicole told the child to get ready for school before eating breakfast. Nicole told the field worker that the child was having a tantrum and Nicole intervened and she may have accidentally scratched the child. The Assessment Summary concluded that the injury was accidental and Nicole could not have reasonably foreseen that her actions would result in injury.

Conclusions and recommendation

Our investigation has brought to light the potential problem of DHS's limited record-retention policy. The absence of records prevents us from reaching any firm conclusion on the appropriateness of DHS's responses to the 2005/2006, 2008, and 2009 reports. These early cases 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.

Record-retention policies in 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. 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.

¹⁶ According to DHS's Employees' Manual, Title 17, Chapter A, page 5, DHS must send the reporter a written notice of the intake decision within five days of receiving a report. This policy was adopted on September 1, 2006, and would have been in effect at the time the teacher said he made an abuse report about Natalie.

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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.**

FIVE CHILD ABUSE REPORTS: NOVEMBER 2015 – MAY 2016

Beginning in November 2015, DHS received ten child abuse reports about the Finn children over an 11-month period. Of those ten reports, eight were rejected and two were accepted for assessment.¹⁷ All ten of these child abuse reports were made by mandatory reporters.

November 18, 2015, rejected intake

DHS received a child abuse report on November 18, 2015, from the principal at Walnut Creek Campus, a West Des Moines Community Schools alternative high school. The audio recording for this call shows the principal reported that Natalie was “very thin,” adding, “So Mom is saying there’s plenty of food at home, she’s just choosing not to eat it, versus the girl seems like she’s starving here.” None of those statements were documented in the intake report.

When Natalie was asked if she had eaten dinner, she always said she got into trouble and she was not allowed to eat. The principal also reported that Natalie was not showering or changing her clothes daily, was hoarding food, and her shoes were falling apart. When people tried to help, Nicole would become defensive and say that Natalie was just manipulating them.

In addition, the principal said the family was running an animal shelter out of the home with 30 animals, and it was unknown if it was a clean environment for the children. The intake report mistakenly documented this as “it is unknown if it is a clean environment for the animals.”

DHS officials determined that the decision to reject this intake was appropriate. We disagree. We believe the principal provided sufficient physical and behavioral indicators to warrant accepting the intake for a family assessment.

¹⁷ All calls answered by CSIU intake workers are recorded and stored electronically. Our office obtained and reviewed the recordings for the first four of these intakes. There are no recordings of after-hours child abuse calls such as the May 31, 2016, intake.

February 5, 2016, rejected intake

DHS received a child abuse report on February 5, 2016, from the school nurse at Walnut Creek Campus. The audio recording for this call shows the nurse reported that Natalie was underweight and malnourished, having not eaten much food at home for the last few weeks. The nurse observed that Natalie's "face is gaunt," and her "clothes are hanging on her." Natalie asked for food from school staff and other students.

The nurse said Natalie wore the same clothes daily, would not bathe, and had body odor and greasy hair. The nurse also said Natalie wore shoes with "big holes in them." That statement was not documented in the intake report.

In addition, the nurse relayed that Natalie said, "We are closed in our room. I have to ask her for everything." While they had plenty of food in the home, Natalie would not get any if she did not ask for it. "Sometimes I just don't ask," Natalie had told the nurse. She inferred that Nicole may have had mental-health issues, describing her as very controlling and manipulative.

This intake was rejected, but DHS officials determined that it should have been accepted. We concur.

April 19, 2016, rejected intake

DHS received a child abuse report on April 19, 2016, from the Student Services Coordinator at Walnut Creek Campus. The audio recording from this call shows the school official reported that Natalie said her mother slapped her and locked her out of the house the day before. Natalie then left and went to a friend's home. Nicole and her ex-husband, Joe, reported Natalie as a runaway that night. Natalie showed up at school the next morning.

The school official did not observe any marks and Natalie did not report any injuries. Natalie told the school official that she was afraid to go home, but later said she was okay going home since her Dad was going to be there. The school official also reported that Natalie had talked about being spanked with a belt in the past few weeks and not getting enough food at home. This intake was rejected and we found no concerns with that decision.

May 27, 2016, rejected intake

DHS received a child abuse report on May 27, 2016, from an attendance caseworker at Walnut Creek Campus. The attendance caseworker said a neighbor who "lives just up the block from Natalie" had come to the school to report concerns about Natalie. "Natalie stopped at her house and said that she was just starving and hasn't had any food and she said that she waited til Mom fell asleep and she snuck out of the house to get some food because she didn't have anything," the attendance caseworker said, adding "this is not the first time that she has done this."

Those statements were documented in the intake report as follows: "A woman came to school and told concerns, she lives near the family. Natalie told this women (sic) that she was hungry and mom did not have any food." Among other things, Natalie's purported statement that she "was just starving" was not documented in the intake report.

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After Natalie left the woman's house, the attendance caseworker said, the woman drove away and saw Natalie "come out of another lady's house with more food." Those statements also were not documented in the intake report. Asked whether Natalie looked malnourished, the attendance caseworker replied, "Yes, she does, she looks very thin." The intake report stated, "Natalie is thin," failing to document the attendance caseworker's statement that Natalie looked malnourished.

This intake was rejected. We agree with DHS officials' determination that this intake should have been accepted. The supervisor who decided to reject this intake later told us that had he known about the statements which were not documented or not documented accurately, "I believe it would have changed my mind to an accept."

When we interviewed the intake worker, she said, "Looking back, I wish to God I would have accepted it." She later added, "I feel so bad in this case, and I'll have to live with this the rest of my life, and out of it I pray that I'm a better worker for it, and I think I am."

May 31, 2016, accepted intake

On May 31, 2016, the West Des Moines Police Department (WDMPD) received two separate calls about children who lived on 15th Street. The first call was from an employee at the Git-N-Go store at 1325 Grand Avenue. According to a WDMPD dispatch log, the caller was concerned about the welfare of two teenage girls who had just left the store. He said the girls appeared to be homeless and one of them was limping.

Patrol Officer Jason Hatcher responded to the call and spoke to the girls, who told him they lived on 15th Street and were home schooled. Officer Hatcher later reported that other than needing to wash their hair, they appeared fine.

WDMPD received the second call about five hours later from a neighbor of the Finns, expressing concern about the Finn children. The responding officer, Matthew Granzow, tried to do a welfare check at the Finn residence. "I knocked on the door multiple times and nobody answered," Officer Granzow later wrote in an incident report, noting that he saw someone "peeking around the curtains." Officer Granzow then called the neighbor and wrote in his report:

[She] advised that one of the teenage girls attends school with her son at Walnut Creek. A couple of weeks ago the girl, who [the neighbor] identified as Natalie Finn, started coming to her house and asking for food and money. She showed up almost every day for a week asking for food and even asked to take extra food home for her sister. [The neighbor's] son reported that while she was at school Natalie would ask other classmates for money and food. Natalie would wear the same clothes for multiple days and had very bad body odor. On one occasion Natalie told [the neighbor] that she does not have shoes and because of that had two blisters on the bottom of her feet. [The neighbor] saw the blisters and said they were large. On that day Natalie was wearing flip-flops, but other days [the neighbor] saw Natalie wearing shoes. Natalie asked [the neighbor] for gauze to wrap up her blisters. On another occasion Natalie reported to [the neighbor] that

she was locked in her bedroom by her mother because one of the pets urinated on the floor. [The neighbor] states that Natalie appears skinnier than average.

[The neighbor] reported seeing Natalie walking out of the first house north of Git-N-Go with food in her hands.

In a separate report, Officer Granzow wrote that it sounded like the Finn children were the same kids who appeared homeless at the Git-N-Go earlier in the day.

Based on the information from the neighbor and Officer Hatcher, Officer Granzow called DHS's Child Abuse Hotline that evening. Because he called outside of CSIU's regular business hours (8 a.m. to 4:30 p.m.), Officer Granzow's call was handled by a field worker who was assigned to handle after-hours child abuse reports received that night from Polk County.

The intake report recounted much of the same information contained in Officer Granzow's incident report, including Natalie asking for food from others and being locked in her room. The intake report also contained information from the prior rejected intakes:

There are three rejected intakes in 2016 stating Natalie said she is not fed enough at home. Lookups show they are adopted and receive subsidy. Natalie is stated to have mental health issues but the school has not received calls back from therapy. Natalie is stated to be severely underweight. Pror (sic) rejects state Mom is controlling and does not let kids have much contact or help from others.

This intake was accepted. All four children living in the Finn residence at that time were identified as "child subjects."

Analysis

A. Thoroughness and accuracy

An integral part of the intake worker's job is to produce a complete and accurate record of the reporter's understanding of the alleged abuse and the surrounding circumstances. However, we found that relevant and substantial information was left out of several intake reports. Most notably, we found that two reporters described Natalie as "starving" and "very thin" (the intakes dated November 18, 2015, and May 27, 2016). Neither intake report included those descriptions and both were rejected.

We reviewed the policies for centralized intake units in several other states. We discovered that for child abuse reports received at Tennessee's centralized intake unit, workers are required to read their written narrative back to the caller. In response to an email inquiry from our office, an official with Tennessee's Department of Children's Services explained, "With us reading back the narrative, we are verifying to the caller that their concerns were heard and documented. We also use this as a way to ensure we have captured all of the necessary details."

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Without such a policy, child abuse reporters in Iowa have no way of knowing whether their reports are documented accurately. Had such a policy been in effect at CSIU in 2015-2016, we believe it may have allowed reporters in the Finn case to point out significant errors and omissions, and may have resulted in several intakes being accepted instead of being rejected.

B. Collaterals

One aspect of accurately documenting callers' statements includes seeking the identity and contact information of sources who are knowledgeable about the child's circumstances, referred to as "collaterals" in DHS policy. Among the five intakes handled from November 2015 through May 2016, four of the reporters provided information they had received from other people. However, none of the four intake workers asked for the identities and contact information of those collateral witnesses. Referring to the need to identify collateral witnesses, CSIU administrator Jason Geyer told us, "That's not been practiced on a consistent basis."

C. 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 – to determine whether to accept a report. The one common concern in these five reports was that Natalie was not getting enough food at home. The fifth intake, however, was the only one in which the prior history was reviewed and the dots connected. That intake was handled by an on-call field worker who had significantly more time to review the prior intakes than is typically afforded to intake workers at CSIU.

We asked the intake workers and supervisors why they had not identified these repeat concerns, despite the policy directive. They said that the expectation was not emphasized as a required practice. One former intake worker told us, "The decision to accept or reject was mostly based on what you heard in the phone call." Intake workers also told us that they simply did not have time to consistently review the prior history.

DHS officials addressed this concern after their internal review of the Finn case. "Intake supervisors are now focusing more on cases where the intake worker is making a preliminary decision to reject a report," stated DHS's Executive Summary Regarding Natalie Finn. "Supervisors are doing a more in-depth review of case history." We believe this change – particularly the expectation for supervisors to review the prior history for intakes with a preliminary decision of reject – is the most significant of DHS's intake-related improvements since Natalie's death.

Recommendations

The Ombudsman recommends that DHS:

- 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 the alleged abuse.**

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.**
4. **Continue monitoring rates by which intake workers collect information on collaterals and continue stressing the importance of collecting that information.**
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.**
6. **Continue to monitor and solicit feedback from intake workers for any concerns about conducting system checks.**
7. **Update its Employees' Manual to explicitly require intake workers to review all prior intakes and assessments, not just rejected intakes.**

ASSESSMENT OPENED ON MAY 31, 2016

Family assessment (June 1 – June 14)

The May 31 family assessment was assigned to field worker Amy Sacco. On **June 1**, Sacco left a voicemail requesting a return call from Nicole and made an unannounced visit to the Finn residence. No one answered so Sacco left a business card in the door.

The next day, **June 2**, Sacco's assessment report stated that she called Walnut Creek Campus and was told that school was out for the summer. According to Sacco's assessment report, she then called Officer Granzow, the reporter for the May 31 intake, and left a message requesting a return call. Sacco did not receive a return call and she made no more attempts to contact Officer Granzow. He told us that he did not recall receiving a message from Sacco.

Sacco made her second unannounced visit to the Finn residence on **June 7**. No one answered so she again left a card in the door. On Friday, **June 10**, Sacco received a voicemail from Detective Kraig Kincaid, who was assigned to investigate the case opened by Officer Granzow.

Sacco made her third unannounced visit to the Finn residence on **June 13**. Nobody answered so she left another card in the door. Sacco later spoke by phone with Detective Kincaid, who told her that he had been to the Finn home several times, but no one answered. Detective Kincaid told us that he asked Sacco if she needed a copy of Officer Granzow's May 31 incident report. Detective Kincaid said Sacco replied that she had the information that she needed.

Also on June 13, Sacco addressed a letter to Nicole, stating in part, "I have received a Family Assessment referral regarding concerns reported to DHS. I would like to meet with you and your children, at your earliest convenience.... I can be reached at my office [phone number] or on my cell phone [phone number]."

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Conversion to child abuse assessment and vacation

Sacco's supervisor, Beth Avery, told DHS officials that she agreed on **June 13** to reassign the case from a family assessment to a child abuse assessment because the safety of the children had not been assured. The new due date for completion was June 28.

June 14 marked the last day Sacco was in the office before her vacation that would last until June 24. On the afternoon of June 14, Sacco received an email from Nicole that read:

Hi, Amy. I had a card in my door last night from you. I also had a card from you that the boys found in the front yard last week. (I thought it belonged to an adopter who came here for my rescue).

I accidentally updated my iPhone this morning and it is stuck in that. I have been waiting all morning to call you. I can only imagine what this is about. Natalie has been having some major issues with her reactive attachment disorder and she always goes into hoarding or survival mode at the end of the school year. This year was especially different because she had more freedom, because she is 16 now, she was at a school where she could leave the property at lunch, and she was walking to and from school.

If my phone unfreezes soon, I will give you a call. If not, I will have to wait for the fully-charged battery to die and call you tomorrow. I don't want you to think that I am ignoring you now that I know that your card was meant for me last week.

Although she read Nicole's email that same day, Sacco told us that she did not respond because she was busy with an unrelated child abuse assessment.

Case activity from June 24 – August 16

When Sacco returned from vacation on **June 24**, she noted that Nicole had left a voicemail at 8 p.m. on June 16. Sacco then called Nicole and left a message requesting a return call.

Avery approved Sacco's request to put the case on addendum.¹⁸ Detective Kincaid filed an incident report which said Sacco told him "she was going to work with the Polk County Attorney's Office to see what we can get done in order to get inside the home."

Sacco completed the initial and subsequent safety assessments on June 24, concluding that the children were safe even though she still had not seen them. Sacco's initial safety assessment stated in part: "The mother Nicole has avoided CPW Sacco and it is believed that Nicole has been home when CPW Sacco has been to the home." After documenting that she suspected Nicole was avoiding her, Sacco made only one attempt to contact Nicole over the next 32 days.

¹⁸ Although child abuse assessments must be completed within 20 business days, field workers can continue working cases beyond that timeframe, but only under certain specified circumstances. This is referred to as an "addendum."

No further substantive action occurred until **July 19**, when Sacco and Avery discussed the case. They agreed that Sacco would miss the addendum deadline (July 27) because Avery would be on vacation from July 21 through August 5.

Avery advised Sacco to continue trying to contact Nicole. When we interviewed Sacco, she said Avery told her that if those efforts were not successful, Sacco should arrange to send Nicole a “county attorney letter,” asking her to attend a “county attorney meeting” on August 8, when Avery would be back in the office.¹⁹ Sacco told us that at that time she had worked on “a couple” of prior assessments that involved the use of a county attorney letter and a county attorney meeting.

Sacco emailed Nicole on **July 26** asking for a phone call. Sacco’s email, her first email of any kind to Nicole, said she would contact the Polk County Attorney’s Office if she did not hear from Nicole by the end of the day on July 28.

After being contacted by Sacco, Assistant County Attorney Jim Ward addressed an **August 2** letter to Nicole, asking her to attend a meeting scheduled for August 8:

DHS has approached our office with concerns about the safety and welfare of your children. DHS is requesting that our office intervene based on the information learned during the investigation.

I would like to give you the opportunity to discuss this matter with me before a final decision is made about how to appropriately handle this matter.

If you would like to take advantage of this opportunity, you need to attend a meeting at the **Department of Human Services, located at River Place, 2309 Euclid Ave., Des Moines, Iowa**. The meeting should take approximately twenty minutes. (Emphasis in original.)

Nicole did not show up for the **August 8** meeting. Sacco and Avery then asked an assistant county attorney to pursue the matter through the juvenile court process that authorizes DHS to enter a home and interview or observe a child when permission has been refused by a parent.

The assistant county attorney filed a “Motion to Compel” the next day.²⁰ A juvenile court judge issued an “Order to Compel” the same day, stating in part:

The Court, being fully advised in the premises and based on said motion, FINDS, that probable cause does exist to grant the motion to compel the interview of the above named children filed by the State. IT IS THEREFORE THE ORDER OF THE COURT THAT the above named children shall be interviewed by DHS.²¹

¹⁹ During her testimony in Nicole Finn’s criminal trial, Sacco said the purpose of a “county attorney letter” and “county attorney meeting” is for child abuse assessments where a family is resistant, and the child’s safety has not been assured, to encourage the parent(s) “to talk about the allegations and to emphasize we need to see the children, we need to assure safety and we need to see the home.”

²⁰ A copy of the Motion to Compel is attached as Appendix A.

²¹ A copy of the court order is attached as Appendix B. The Order included a handwritten note, apparently initialed by the judge, which stated, “And DHS is authorized to enter the home to interview or observe the children.”

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Sacco received the court order and emailed a copy to Nicole on **August 10**. Sacco then called Detective Kincaid to schedule a time to meet at the Finn residence to serve the court order.

Sacco met Detective Kincaid at the Finn residence at 2 p.m. on **August 11**. According to Sacco's report, Detective Kincaid "knocked on the doors and the windows in attempts to get someone to answer the door. Through the front window CPW Sacco observed a teenage boy standing in the living room, but he quickly left the area."

Sacco called Nicole and left a message asking her to come to the door. When Nicole did not do so, Sacco and Detective Kincaid left the property. In his August 11 incident report, Detective Kincaid wrote in relevant part, "Amy advised that she was going to speak with the county attorney again to see what else can be done to interview the kids."

According to Sacco's report, she received a phone call from Nicole that evening. Nicole said she was sick with lupus and fibromyalgia and that was why she had not answered the door earlier in the day. Sacco tried to set up a time the next day to meet but Nicole became argumentative.

On Friday, **August 12**, and Monday, **August 15**, Sacco called Nicole and left messages requesting a return call. Sacco left another message for Nicole on Tuesday, **August 16**, and then recontacted the county attorney's office. Sacco later told DHS officials that she was advised to treat the Order to Compel as a search warrant.

August 17 visit to the Finn family residence

Sacco and Detective Kincaid arrived at the Finn residence at 1:30 p.m. Detective Kincaid was accompanied by two officers and another detective. Sacco wrote that the four police officers knocked on all doors and windows and Detective Kincaid announced "if the door was not opened the door was going to be breached."

Detective Kincaid's report stated that Nicole opened the front door, but she indicated she did not want them to enter. He wrote that it "had to be explained numerous times that the court order signed by the judge granted us access to the residence and interviews with the children. She remained in the door and argued and finally I just walked past her into the residence."

Sacco followed behind and found all four children inside the home. Since the May 31 child abuse report, **78 days** had elapsed before Sacco made contact with the Finn children.

Sacco and Detective Kincaid found that the family appeared to have an adequate supply of food. Sacco wrote that the home was very dirty and cluttered, with several dogs in crates and several cats in the home. Sacco found no locks on the bedroom doors. She stated that each child had their own bed and adequate clothing.

Sacco told our office that when she initially tried to engage the children, Nicole would interrupt, telling Sacco that she was not going to interview her children alone. According to Sacco, she tried to get Natalie to leave the room with her, but Natalie refused. Natalie told Sacco to "fuck off" and said she and her siblings were safe. "Natalie stated that she wasn't going to say anything because she didn't want to be taken away from her mother," Sacco's report stated. Soon after, however, Sacco began receiving some substantive responses from Natalie:

CPW Sacco asked Natalie why she was seen pan handling for money and going to neighbors' homes asking for food. Natalie stated that she is addicted to junk food and her mother doesn't allow Natalie to eat junk food. Natalie stated that she was pan handling to buy junk food and was asking the neighbors to specifically give her junk food. Natalie stated that last school year she stole \$60 from another student to buy junk food.

Sacco then spoke with Nicole and tried to provide her with information about voluntary services designed to help families and adoptive parents "but Nicole was not interested in the information." Nicole reported that she had previously started an application to admit Natalie into a psychiatric institute for children, but she had not finished it. According to Sacco's report, she encouraged Nicole to contact the facility to restart the application process. "CPW Sacco discussed with Nicole the importance of getting Natalie's mental health under control especially since Natalie will be 18 in less than two years," Sacco's report stated.

Sacco also wrote that Natalie and her siblings "appeared to be thin ... but didn't have any visible signs of being undernourished." Detective Kincaid, who had previously seen some of the children at school, told us that he did not observe anything unusual with their appearance that day.

Sacco encouraged Nicole to use any and all resources to help her children. Nicole stated that she did not need any help because she knew what was best for her children. Sacco told Nicole that if DHS continued to get reports about the children, there could be other assessments.

Back at her office, Sacco discussed her findings with Avery. They agreed to keep the case open so Sacco could get the children's medical records. Avery later told DHS officials that the goal was "to make sure that if the kids are thin that they really are ... that's really their natural state; that they're thin children. Not that they have necessarily been losing weight."²²

Case-related activity from August 18 – October 24

According to her assessment report, Sacco called the children's doctor on **August 18** and requested medical records for all the Finn children. Sacco made additional calls to the doctor's office on **September 12** and **October 17**. Those three phone calls constituted the only action Sacco took on the addendum over a 67-day period.

Analysis

We found a number of serious missteps with how the May 31 assessment was handled by Sacco and Avery. Key witnesses were never identified or interviewed, the case was plagued by procedural irregularities, and the case was allowed to languish for extensive periods of time.

A. Failure to identify and contact neighbor

The neighbor who was referenced in the May 31 intake report as seeing Natalie's very concerning behavior first-hand was an instrumental witness in the case. Although the intake

²² Transcript of DHS's interview of Avery, November 7, 2016, page 26.

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report did not identify the neighbor, it did identify the officer who spoke with her. Presumably, all Sacco needed to do to identify the neighbor was to speak with Officer Granzow or obtain his incident report. The day after Sacco was assigned to the case, she called Officer Granzow and left a message. Sacco did not receive a return call and she made no more attempts to reach him. Sacco told us that she did not know why she did not continue trying to reach Officer Granzow.

Detective Kincaid said Sacco told him that “she had the information that she needed” and so he did not send her Officer Granzow’s incident report. Had Sacco obtained that report, she would have learned that the neighbor reported seeing large blisters on Natalie’s feet. This alleged physical injury was *not* included in the May 31 intake report. We interviewed the neighbor and found she had even more information than was contained in the police report:

Neighbor: She was limping. I said, “What’s wrong, Natalie?” “Oh, I don’t know.” I said, “Did you do something to your leg or your foot, or something?” She sat down, and I said, “Let me see your feet.”

Ombudsman: And what did you see?

Neighbor: They were like broken blisters, like blood, not scabby, but like just smeared blood on the bottom of her feet.... It seriously looked like somebody burned her feet, to me. That’s what it looked like, because they were not in places where you would get a blister from walking.

If Sacco had been privy to the neighbor’s opinion that it “looked like somebody burned” Natalie’s feet it could have led to a physical abuse allegation.

B. Failure to contact Natalie’s mental health therapist

Avery later told DHS officials that Sacco expressed concern about Natalie’s mental health diagnosis and “mom was not getting her the mental health treatment. So that was something that (Sacco) definitely was interested in making sure that she got her back into.”²³ But Sacco did not act on her concerns about Natalie’s mental-health issues.

C. No attempt to contact children’s father

Among the parties that a field worker must attempt to interview during a child abuse assessment are the parents of an abused child. Joe Finn’s name and address or phone number was on all of the intake reports. The Finn children were still spending weekends at their father’s house through the first month of the assessment. If Sacco had contacted Joe before her mid-June vacation, or even shortly after her return, Sacco might have been able to speak with the children at their father’s residence and away from their mother. But Sacco never contacted Joe.

D. Failure to reassign the case during extended leaves

Sacco went on vacation from June 15 to June 24. During Avery’s interviews with DHS officials and our office, she acknowledged that she should have reassigned the case to another field worker in light of Sacco’s absence and the fact that Sacco had still not seen the children to assure

²³ Transcript of DHS’s interview of Avery, November 7, 2016, page 24.

they were safe. We also found that Avery failed to reassign the case during Sacco's second extended leave (September 16 to October 13).

E. Failure to take timely steps

Nicole's June 14 email was her first communication of any kind to Sacco. But Sacco did not respond to that email until July 26, a delay of 42 days. Another failure to act in a timely manner relates to the county attorney letter, which should have been sent much sooner, ideally within the first 20 days of the assessment. We believe the continuous delays had a practical effect on Sacco's ability to determine what was actually going on in the home and allowed Nicole time to coach her children and present a functioning home to DHS and law enforcement.

Sacco's lack of urgency in the case only got worse after deciding to keep the addendum open to seek the children's medical records. As of August 18, the addendum was already 23 days beyond its due date. As of October 24, it was 90 days overdue.

Avery's lack of oversight in the case deserves its own criticism. As a veteran child-welfare employee with 19 years of experience with DHS, and 34 years of experience overall, Avery should have realized that putting the case on addendum in late June was a "last resort" to assess the safety of the children. This made Avery responsible to ensure that the case was handled in a timelier manner so as not to miss another deadline. She did not meet that responsibility.

F. Botched execution of the court order

Sacco should *not* have sent the court order to Nicole before executing that order. Doing so expanded the opportunity for Nicole to prepare before Sacco entered the home and observed the children. Sacco also should not have left the Finn residence on August 11 without calling the county attorney's office to request advice or without consulting Avery.

G. Caseload

When we interviewed Avery, she acknowledged that she and Sacco made mistakes in their handling of the May 31 assessment. But Avery also referred to "this unrealistic caseload" which she said hindered their ability to meet their obligations. "I believe that this situation is overwork of the worker," Avery told DHS officials. "I also believe that it's going to happen again. And so I would hate for this whole thing to happen and then have us say, well the problem was Amy Sacco and Beth Avery and not take a look at the systemic problem we have."²⁴

Sacco told us that due to her caseload, "It always felt like you were running with your head on fire." As a result, Sacco said, the Finn assessment "went on the back burner."

DHS officials told us that the recommended national standard for field workers is no more than 12 new cases each month (including family assessments and child abuse assessments, as well as dependent adult abuse assessments).²⁵ "There's 20 workdays in a month," Sacco told us. "You can assume you get one case a day, so you're getting 20 cases a month."

²⁴ Transcript of DHS's interview of Avery, November 16, 2016, pages 57-58.

²⁵ DHS letter from Mikki Stier, November 8, 2018.

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DHS data, however, showed that Sacco's average monthly caseload in 2016 was 14.1. That was above the recommended national standard, but not the dire situation portrayed by Sacco and Avery. "That is in line with what all of our other staff were at that time as well," said Vern Armstrong, Administrator of DHS's Field Operations Division.

Conclusions and recommendations

Opened on the last day of May, the Finn assessment should never have hinged on a mid-August home visit. Instead, Sacco should have been in contact with the children's father and the neighbor who had called police within the first week or two of June.

Had Sacco made just those two contacts without delay, that could very well have led to three significant differences in how the assessment proceeded. First, Sacco may have been looking at an additional allegation of physical abuse, based on the neighbor's observations of the blisters on Natalie's feet. Second, Sacco might have been able to interview the children at their father's home or at school, away from Nicole, which may have allowed Sacco to better understand what was actually going on at Nicole's residence. And if that happened, Sacco would have been able to assess the children's safety within the first 20 days, avoiding the need to involve the county attorney's office and seek a court order. Nobody will ever know what might have transpired if Sacco had taken just those basic steps in a timely manner.

We also found that some of the failures in the Finn case were not anomalous. In 2006, DHS officials conducted a statewide review of both the intake and assessment sides of its child welfare program. A summary document stated that one of the concerns on the assessment side was a failure to interview all necessary collaterals.²⁶ The summary document did not elaborate.

The next review of its kind was conducted in 2017 in the aftermath of Natalie's death. Reviewers found several assessment-side concerns in 2017 that were identical to concerns found in the handling of the Finn assessment:²⁷

1. Field workers did not contact all necessary collaterals in 58 of 249 assessments reviewed (23 percent).
2. Field workers did not contact the reporter in 100 of 216 assessments reviewed (46 percent).
3. Field workers did not contact the non-custodial parent in 60 of 177 assessments reviewed (34 percent).

DHS officials conducted a similar review in 2019. With one exception, reviewers in 2019 again found several assessment-side concerns that mirrored concerns found in the Finn assessment:²⁸

1. Field workers did not contact the reporter in 26 of 67 assessments reviewed (39 percent).

²⁶ *CPS SYSTEM REVIEW STATE SUMMARY*, page 1.

²⁷ From *2017 Intake and Assessment Case Review April to December 2017*.

²⁸ *CPA Review of Accepted Intakes and Assessments, 1st Quarter 2019*.

2. Field workers did not contact the non-custodial parent in 10 of 49 assessments reviewed (20 percent).
3. Field workers did not correctly open an addendum in 4 of 10 addendums reviewed (40 percent). This was a new issue which had not been included in any of the previous systemic reviews.

Those findings suggest that several of the failures in the handling of the Finn assessment were still systemic three years later. The 2019 review found that field workers failed to contact all necessary collaterals in only 1 of 75 assessments reviewed (1.3 percent). That suggests there has been systemic improvement by field workers on the need to contact all necessary collaterals.

The Ombudsman recommends that DHS:

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.**
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 not 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.**

THREE CHILD ABUSE REPORTS: SEPTEMBER – OCTOBER 2016²⁹

While Sacco's assessment was still on addendum, DHS received three additional child abuse

²⁹ Our office obtained and reviewed the recordings for the last two of these intakes. There was no recording for the September 2, 2016, intake due to a system malfunction.

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reports involving the Finn family. Under established DHS practice at the time, new intakes about individuals who were already the subjects of an open assessment were forwarded to the

field worker and that worker's supervisor. It was up to them to decide how the new intake should be handled. Rejected intakes handled in this manner were referred to as "urgent rejects."

September 2, 2016, "Urgent reject"

DHS received a child abuse report on September 2, 2016, from the principal who had also made a report about Natalie in November 2015. The principal raised concerns based on her experience with the Finn family the previous school year. The principal had not had contact with the family since May so the only new information was that Natalie would not be attending school that year. This intake was handled as an "urgent reject" – meaning it was rejected but the information was conveyed to Sacco and Avery.

October 5, 2016, "Urgent reject"

DHS received a child abuse report on October 5, 2016, from a counselor at West Des Moines Valley High School. The audio recording shows the counselor reported that one of Natalie's siblings "appears to not be eating" and looked "extremely thin, gaunt." The child told the counselor that they had to earn food by practicing good hygiene and keeping their room clean. But the child had not showered in a week and told the counselor, "I don't eat very much in my house."

The counselor further reported that the child had to ask permission to use the restroom in the middle of the night because Nicole thought the child would "sneak water." When the child was caught "sneaking water" the night before, Nicole gave the child a time out. The counselor said the child had already missed 14 days of school that year. This intake was also handled as an "urgent reject."

October 12, 2016, Rejected intake

DHS received a child abuse report on October 12, 2016, from two administrative employees of the West Des Moines Community Schools. The two employees expressed concern about one of Natalie's siblings not attending school since September 20, except on October 5 for a couple of hours. Both school employees reported that Natalie had not been to school that year. "We're very concerned for where she is and what she's doing and her safety," added one. The other said, "We've reached out to Mom, she won't return our calls." This intake was rejected. Unlike the two prior intakes, this intake was not handled as an urgent reject.

Conclusions and recommendation

Both Sacco and Avery received emails about the two urgent rejects. Avery confirmed receiving the emails, but said she did not read them as she believed that was Sacco's responsibility. Sacco later told DHS that she did not see the September 2 email, but she remembered "physically reading" the October 5 intake.³⁰ Even if Sacco had reviewed the September 2 intake report, we

³⁰ Sacco was out of the office on October 5 and did not return to work until October 10.

are uncertain what action, if any, she should have taken. The issue of Natalie not attending school was not, in and of itself, a child abuse issue. The October 5 intake was a different story, however. The report included new concerns about the physical appearance of one of Natalie's siblings and their access to food and water, but Sacco and Avery took no action in response to the October 5 report.

The Ombudsman recommends that DHS:

- 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.**

ADDITIONAL CONCERNS IDENTIFIED DURING THE INVESTIGATION

Intake worker positions remain static

Child abuse call volumes and accepted intakes have increased significantly since Natalie's death. This has resulted in significant increases to field workers' average caseloads. The number of assessments assigned to field workers increased from 25,707 to 35,029 from 2016 to 2018, a staggering 36 percent. Fortunately, additional funding for field staff was approved in 2019.

The increased call volume is also straining CSIU, but the number of intake workers has not increased. When CSIU received its first report in 2010, it employed 21 intake workers. By 2011, that number had expanded to 23, but it has not changed in the subsequent eight years.

Unit administrator Geyer told us that the increased call volume in recent years is manageable "if everybody is here, all 23 workers." He added, "But as soon as three of those people are gone – I mean, it's staffed pretty tight, I'll say that." In 2016, DHS records show, three people left the job of intake worker at CSIU. But in the two-year period of 2017 and 2018, at least 10 people left the intake-worker job, including three who handled an intake about the Finn family. We found that the spike in turnover has had a significant detrimental impact on CSIU's daily operations.

Nearly everyone we interviewed said that CSIU needs at least three to five additional intake workers. But since CSIU's inception in 2010, officials have never requested an increase in funding specifically for CSIU operations.³¹ Service Area Manager Lori Lipscomb told us, "With a status-quo budget, there's nothing to ask for. There's no money for additional positions."

Hold times increasing

Before 2017, CSIU management had a goal of keeping average hold times to 45 seconds or less. Otherwise, Geyer said, "You're gonna lose people and we don't want to lose anybody." He said the average hold time now is just under two minutes and on a busy day, some calls could be on hold for 10 or 12 minutes. "And I think that makes everybody a little nervous," Geyer said.

³¹ DHS letter from Mikki Stier, November 8, 2018.

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Speed versus quality

We found significant tension at CSIU between the dual expectations of speed and quality. Intake workers are trained to document as much as possible for the intake they are working on, but also know they need to move to the next call as soon as possible. We believe pushing workers to process intakes quickly may have been at least part of the reason for the widespread policy noncompliance we found with the intakes involving the Finn family. One CSIU employee told us, “As call volume increases, we see more mistakes that are made.”

We believe it was not a coincidence that among the five intakes between November 2015 and May 2016, the only intake which met the policy expectation to include relevant history from prior abuse reports was handled on an after-hours basis by a veteran employee with significant experience in both the intake and assessment sides; and who had significantly more time than is typically afforded to intake workers at CSIU. This suggests that slowing the process a bit can create opportunities for increased quality.

Little meaningful training

After their first year of employment with DHS, social work staff are required to complete 24 hours of child-welfare training annually. For fiscal year 2017 (which ended June 30, 2017), DHS reported that only 49 percent of “ongoing social work field staff” met this requirement.³² For the five intake workers we interviewed, their compliance with this requirement has been approximately 24 percent – substantially lower than the agency-wide figure of 49 percent.

Secondary trauma and decision fatigue

DHS intake workers and field workers are subject to secondary traumatic stress, which has been described as a set of observable reactions to working with people who have been traumatized; the condition mirrors post-traumatic stress disorder.³³ Left unaddressed, the symptoms can result in mental and physical health problems and poor work performance. When we asked unit administrator Geyer about secondary trauma, he replied, “It’s a real thing for sure.” He added that intake workers “hear as much, if not more (than field workers) every day about how kids are hurt, or about how adults are hurt. You know, just bad stuff every day.”

CSIU supervisors are exposed to decision fatigue, which can be explained as “the deteriorating quality of decisions an individual makes after a long period of continuous decision making. In other words, the mental work of being a ‘decider’ wears down an individual’s capacity to make sound judgments through mental exhaustion.”³⁴

Not enough time to take breaks

We found that intake workers do not routinely take full advantage of regularly scheduled breaks. The intake workers we interviewed said that working through breaks is common. One worker

³² DHS’s “Iowa Child and Family Services Review Statewide Assessment” February 15, 2018, page 101.

³³ “Secondary Traumatic Stress,” <https://www.acf.hhs.gov/trauma-toolkit/secondary-traumatic-stress>.

³⁴ Becker’s Hospital Review, *Bad choices: 13 things to know about decision fatigue*, available at <https://www.beckershospitalreview.com/hospital-management-administration/bad-choices-13-things-to-know-about-decision-fatigue.html>.

told us she could not remember the last time she had a full lunch break. In addition, since late 2017, intake workers have been limited to 40 minutes of personal time per month.

Mandatory reporters

Individuals in professions that have routine contact with children are required to make a child abuse report when they reasonably believe a child has been abused. All ten of the child abuse reports about the Finn children in 2015-2016 were made by mandatory reporters. Although mandatory reporters are required to submit a written report, only four of those ten mandatory reporters did so.

Prior to Natalie's death, nobody at CSIU was designated to review written reports from mandatory reporters regarding rejected intakes. This means it is unlikely that anyone reviewed the statutorily required written reports submitted by the mandatory reporters in the Finn case – or any other written report from a mandatory reporter for a rejected intake before 2017. CSIU has since implemented a new practice whereby the two Social Worker 4's are assigned to review written reports from mandatory reporters for rejected intakes.

Conclusions and recommendations

We asked a CSIU employee whether every child abuse report receives the level of scrutiny that is required by policy and law. She replied “no” and added, “We're all human, and volume is high. You know, you get intake decision fatigue. There's many different factors that go into it. So I think we all make mistakes.”

CSIU staff are tasked with unrealistic expectations and requirements. Their challenges are exacerbated any time too many staff are absent or when there is turnover, particularly when the unit is operating at peak call volume. The obvious resolution to address these problems would appear to be to hire more staff and create additional efficiencies.

According to DHS officials, our review was the first independent investigation of CSIU's intake process since the unit's inception in 2010. Our investigation included a visit to CSIU on a weekday morning. During our site visit and interviews, we found the staff to be dedicated professionals with a strong work ethic rooted in a desire to serve victims of abuse and their families. “I know that everyone at intake, their heart is truly in there for the protection of children or they wouldn't be there,” one former intake worker told us. “And they feel awful when something falls through the cracks.”

We believe another tragedy could happen if DHS field and intake workers are not given the resources and support they need and deserve.

The Ombudsman recommends that DHS:

- 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 requirement for ongoing training. If DHS**

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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 the 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.**
- 12. Create an online child abuse reporting system for child abuse reports where there is no immediate danger to the child.**
- 13. Modify policy and training to instruct CSIU intake staff to consider giving more weight to child abuse reports made by mandatory reporters.**
- 14. Provide training and resources for intake and field staff impacted by secondary trauma, decision fatigue, and other job-related stress.**

DHS'S REPLY TO THE REPORT AND OMBUDSMAN'S COMMENT

DHS is accepting 11 of the Ombudsman's 14 recommendations. This was a tragic case," Director Kelly Garcia wrote. "The Finn children should never have had to endure the treatment they received."

"We will learn from this and improve the safety net DHS provides to Iowa's children," she added. "Some of the work to improve the Department's response began immediately, but a large part of the Department's ongoing efforts will focus on finding better ways to support our team so they can better support the families we serve."

The Ombudsman will monitor and/or pursue implementation of the recommendations that were not accepted.³⁵

³⁵ DHS's reply to the report begins on page 152 of the report. The Ombudsman's Comments begin on page 157.

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 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 serves two main purposes. The first is to announce our investigative findings and conclusions about the Iowa Department of Human Services' (DHS) handling of child abuse reports involving Natalie Finn and her biological siblings. The second purpose is to present the Ombudsman's recommendations for changes to strengthen DHS's child welfare program.

It should be noted that we found many actions or decisions by DHS 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 DHS policies and procedures. This report also examines policies, procedures, and practices the Ombudsman found could be improved.

The investigation took an extended amount of time due to the complexity of the facts and DHS policy and practice. We also made a significant effort at trying to identify all West Des Moines Community Schools employees who had possibly made a child abuse report to DHS about the Finn children. This effort was stymied by DHS's administrative rules that limit the retention of rejected child-abuse intakes to three years³⁶ and most other child-abuse records to five years.³⁷ We will discuss record retention in greater detail later in this report.

³⁶ IOWA ADMIN. CODE r. 441—175.24(4)(c).

³⁷ IOWA ADMIN. CODE r. 441—175.32.

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INVESTIGATIVE PROCESS

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

Documents and records

Our findings and analysis rely on the 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 Finn family. This included audio recordings from phone conversations between reporters and intake workers, and audio recordings of post-call consultations between intake workers and supervisors.
- Reports and transcripts from DHS's internal investigation.³⁸
- Transcripts of the court testimony of several relevant witnesses in the criminal trial of the adoptive mother in December 2017.
- Basic course training materials for DHS intake workers and field workers.
- The training histories of the five intake workers we interviewed.
- Timesheets for the field worker who conducted the assessment involving the Finn family in 2016.
- The autopsy report on the death of Natalie.
- West Des Moines Police Department case files involving the Finn family, including the investigation into Natalie's death.

³⁸ During our investigation DHS officials provided our office with several documents which summarized the findings from their internal review of the Finn case. As part of their internal review, DHS officials also conducted a series of interviews of a field worker and her supervisor, both of whom were placed on administrative leave on October 25, 2016. DHS transcribed these interviews and provided the transcripts to our office pursuant to our investigation. Throughout this report we will refer to these transcripts as follows:

1. DHS's interview of Sacco, November 1, 2016.
2. DHS's interview of Avery, November 7, 2016.
3. DHS's interview of Sacco, November 10, 2016.
4. DHS's interview of Avery, November 16, 2016.

- The Ombudsman’s public report issued in 2000 concerning the death of Shelby Duis.³⁹

Interviews

During the investigation, we interviewed and took sworn testimony from 30 witnesses. Combined, the transcripts of these interviews exceeded 2,800 pages.

These witnesses included:

- Eleven current and former employees of the West Des Moines Community Schools, most of whom made a child abuse report about the Finn family.
- A neighbor who befriended Natalie and who was referenced in several of the child abuse reports made to DHS.
- Two West Des Moines police officers who attempted to check the welfare of the Finn children in 2016.
- Five DHS intake workers who received six child abuse reports about the Finn family.
- A DHS field worker who received an after-hours child abuse report in an on-call capacity.
- A DHS field worker who was assigned to investigate the after-hours child abuse report and her supervisor. (Following their internal investigation, DHS officials fired both employees.)
- The former administrator for DHS’s Division of Adult, Children and Family Services, who retired in 2018.
- The administrator for DHS’s Division of Field Operations.

We also conducted follow-up interviews with four witnesses after receiving new or additional information from other witnesses or documents.

We sought to identify any West Des Moines Community Schools employee who ever made a child abuse report to DHS about the Finn children. In each of the interviews with school employees who made child abuse reports about the Finn family in 2015 or 2016, we asked whether they knew of any other person who may have also made a report. Based on that information, we contacted 11 additional school employees, two of whom said they made a report about the Finn family (one in 2009 and the other in 2016). DHS officials informed us that they had no record of a child abuse report about the Finn family from either of these two individuals. Due to the statements of one of the individuals, we reviewed the school’s phone records from a five-month period in 2016, but were unable to find any corroborating information.

³⁹ 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>.

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Lastly, in response to our request, West Des Moines Community Schools officials identified over 260 past and current employees who may have had regular contact with the Finn children. They then contacted current employees on the list and asked whether they made a child abuse report about the Finn children; the answer by all questioned was “No.”

We also contacted four individuals from the Finn family’s neighborhood and asked if they had made any child abuse reports about the Finn children. Of the four, three denied making any child abuse reports about the Finn family; one said she had.

FINN FAMILY MEMBERS

At the time of Natalie’s death, the members of the Finn family included:

Nicole Finn: Adoptive mother.

Joe Finn: Adoptive father, divorced from Nicole and not residing in the same household as Nicole and the children.

Natalie Finn (16 years old), **XXXX Finn** (15 years old), and **XXXX Finn** (14 years old): Biological siblings, adopted by Nicole and Joe Finn.

XXXX Finn (15 years old): Also adopted by Nicole and Joe Finn.

EFFECT OF CONFIDENTIALITY ON THE REPORT

We spent a fair amount of time deliberating over what information should be included in this public version of the report. This included consultations with DHS officials and their assistant attorney general, as well as other ombudsman offices.

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 records involving the Finn 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 touched the Finn case. Media reports had identified some of the people who reported suspected abuse to DHS, police officers and medical rescue personnel who responded to a 911 call from the Finn residence. Media reports also identified family members.

After these deliberations, we concluded that it served little public purpose to “out” dedicated DHS front-line workers whose errors we found were often more indicative of systemic problems than employee-performance issues. This report does identify a number of other DHS employees, particularly supervisors, as well as two former DHS field employees whose names have already been made public because of their terminations related to their role in the Finn case.

Aside from DHS employees, we chose not to redact the names of the West Des Moines police officers involved in the Finn case, or the Polk County assistant attorney. We believe there is no expectation of anonymity associated with these professions

Through our investigative interviews, we discovered that many of the people who reported abuse continued to carry a heavy emotional burden, despite doing exactly what was expected of them. We believe the story can be told without identifying them in the report.

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

Introduction

THE DEATH OF NATALIE FINN

She was a very bubbly, vivacious young lady who was always kind of bebopping around the school, so she was a presence in the school.

Walnut Creek Campus principal

I can never stop thinking about Natalie. I can never stop thinking about all the horror and what I had seen and my experience with her.

Neighbor who befriended Natalie

Shortly before 8 p.m. on October 24, 2016, West Des Moines police officers and medical rescue personnel were called to 805 15th Street in West Des Moines regarding a report of cardiac arrest.⁴⁰ Sixteen-year-old Natalie Finn was found unresponsive and not breathing, and she appeared thin and malnourished to the officers.⁴¹ Natalie was taken by ambulance to Iowa Methodist Medical Center.⁴²

“She was wearing an adult type diaper and appeared to have been laying on the floor of a bare room in her own waste for some time,” Detective Chris Morgan wrote in his report. He also wrote that Natalie’s two biological siblings “were admitted to the hospital because they too were severely underweight and also had bedsores about their bodies.”

A pediatrician who treated Natalie at the hospital later testified that the teenager’s body looked “like skin stretched over bones and almost white in appearance.”⁴³ Natalie was so emaciated that the pediatrician thought she had “some horrible, underlying condition like cancer.”

Natalie was pronounced dead the next day at 1:20 a.m.⁴⁴ Her cause of death was later determined to be emaciation due to denial of critical care.⁴⁵ Natalie was also found to be suffering from dehydration. Her weight upon being admitted to the hospital was 66 pounds; she had weighed 107.2 pounds at a doctor visit on February 22, 2015.⁴⁶

⁴⁰ West Des Moines Police Detective Chris Morgan, *Search Warrant*, November 2, 2016, page 5.

⁴¹ *Id.*

⁴² *Id.*

⁴³ Lee Rood, *Natalie Finn was in distress for 15 minutes before 911 call, dispatcher testifies*, Des Moines Register, December 1, 2017. The article was based on testimony at the criminal trial of Natalie’s mother, Nicole Finn.

⁴⁴ Frank Garrity, M.D., *Report of Investigation by Medical Examiner*, December 5, 2016.

⁴⁵ *Id.*

⁴⁶ *Id.*

Asked why Natalie died, Dr. Frank Garrity, who conducted the autopsy for the Polk County Medical Examiner, later testified, “Likely the result of cardiac arrest” from starvation.⁴⁷ According to medical testimony at the mother’s trial, Natalie’s two biological siblings, who were admitted to the hospital, needed months to recover.⁴⁸

When officers were in the Finn home on October 24, 2016, they observed many animals roaming freely, including more than a dozen cats and numerous dogs in kennels.⁴⁹ A report by the West Des Moines Fire Department stated: “It was noted that there was a distinctive smell of excrement in the home and numerous locations where the animals had overfilled the litter boxes and they had begun to defecate on the floor of the home.”⁵⁰

Following a police investigation, Nicole and Joe Finn, Natalie’s adoptive parents, were criminally charged. Nicole was subsequently convicted and received four life sentences. Joe pled guilty and received three 10-year sentences to be served consecutively.⁵¹

DHS’S INTERNAL INVESTIGATION

The “DHS Executive Summary Regarding Natalie Finn” (DHS’s internal investigation)⁵² described the agency’s internal investigation:

As soon as the report of Natalie’s medical emergency and death was received, the department started reviewing its actions in this case. It quickly became clear that personnel investigations were necessary. All child abuse intakes and assessments received regarding the Finn family were reviewed, as well as adoption approval records. Throughout the course of the review, law enforcement reports, medical reports, and school records were received and reviewed.⁵³

Following their internal review, DHS officials fired a field worker and her supervisor on December 16, 2016. DHS management also conducted “coaching and counseling” disciplinary actions with two intake workers and two supervisors who handled four child abuse reports related to the Finn family.⁵⁴

⁴⁷ Lee Rood, *Nicole Finn repeatedly ignored officer, caseworker trying to see her*, Des Moines Register, December 5, 2017.

⁴⁸ Lee Rood, *Nicole Finn convicted of murder in daughter’s starvation death*, Des Moines Register, December 14, 2017.

⁴⁹ West Des Moines Police Detective Chris Morgan, *Search Warrant*, November 2, 2016, page 5.

⁵⁰ West Des Moines Fire Department, *Out of Hospital Care Report*, October 24, 2016, page 2.

⁵¹ Nicole Finn was charged with one count of first-degree murder, one count of child endangerment resulting in death, three counts of child endangerment causing serious injury, three counts of first-degree kidnapping, and three counts of neglect or abandonment of a dependent person. A jury found her guilty of one count of first-degree murder and three counts of first-degree kidnapping. Joe Finn was charged with three counts of child endangerment causing serious injury, three counts of first-degree kidnapping, and three counts of neglect or abandonment of a dependent person. He pled guilty to three counts of assault while participating in a felony causing a serious injury.

⁵² Department of Human Services, *DHS Executive Summary Regarding Natalie Finn*, (2017). This document was provided to our office in early 2017 and was based on DHS’s internal review of the Finn case.

⁵³ *Id.* at page 1.

⁵⁴ *Id.*

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DHS officials implemented a number of changes following their internal investigation, however they made no recommendations for changes in statute or policy.⁵⁵

OMBUDSMAN INVESTIGATION AND THE ROLE OF OTHER OVERSIGHT BODIES

The Ombudsman first heard of Natalie Finn on December 8, 2016, through media reports that DHS allegedly had failed to investigate reports of a starving child prior to her death. The media reports, if true, raised startling concerns about how DHS handled the reports.

We issued a notice of investigation to DHS that same day, and requested all child abuse intakes and assessments involving the Finn family.

There were, however, other government bodies with oversight responsibilities that could have reviewed the circumstances surrounding Natalie's death and DHS's actions in the case. To avoid duplication of efforts, we first needed to determine what specific role our office would have compared to these other oversight agencies.

Role of the Child Fatality Review Committee

In 2000, just months after the death of Shelby Duis, Iowa lawmakers approved a new law authorizing the creation of an ad hoc committee to investigate DHS-related child fatalities.⁵⁶ 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.”⁵⁷

A CFRC can only be convened upon a request from a legislator or the governor in cases when a child abuse report was filed with DHS within two years preceding the child's death.⁵⁸ It is worth noting that the State Medical Examiner is not required to convene a CFRC when requested.

According to state law, the CFRC would consist of a medical examiner, a pediatrician, and a person involved with law enforcement. The State Medical Examiner's office is required to provide staffing and administrative support to the committee.⁵⁹ The CFRC would be required to consult with any local multidisciplinary team, a group of varied experts with the knowledge and skills related to the diagnosis, assessment, and disposition of child abuse cases.⁶⁰ The CFRC may also consult individuals with “specific child death expertise as necessary.”⁶¹

The CFRC would have broad access to sensitive information, including patient records and other confidential information. It is required to review various specified records, including but not

⁵⁵ DHS's Executive Summary, page 1.

⁵⁶ IOWA CODE § 135.43(4).

⁵⁷ *Id.*

⁵⁸ IOWA ADMIN. CODE r. 641—92.4.

⁵⁹ IOWA ADMIN. CODE r. 641—92.3.

⁶⁰ IOWA CODE § 235A.13(8). Seventy counties have a multidisciplinary team, according to a June 4, 2019, letter of response from Deputy DHS Director Mikki Stier.

⁶¹ IOWA ADMIN. CODE r. 641—92.3.

limited to: all child abuse reports and assessments involving the child; all relevant law enforcement records; all relevant medical records; and all relevant court records.

Upon completing its review, the CFRC would be required to issue a report to the Governor and the Legislature detailing its findings and recommendations to prevent child fatalities.⁶² The CFRC is also authorized to redisseminate the confidential information in its report.⁶³

Clearly the purpose of a CFRC is to review fatality cases such as that of Natalie Finn. Notably, however, since the legislation was passed in 2000 authorizing its creation, *the committee has never been convened.*

Clearly the purpose of a CFRC is to review fatality cases such as that of Natalie Finn. Notably, however, since the legislation was passed in 2000 authorizing its creation, *the committee has never been convened.*

In late December 2016, then-Senator Matt McCoy formally requested that the State Medical Examiner, Dr. Dennis Klein, convene a CFRC to review DHS's role in Natalie's death. In a letter dated February 3, 2017, Dr. Klein provided several reasons for declining the request.

First, he concluded that the members of an ad hoc CFRC – a medical examiner, a pediatrician, and a law enforcement professional – would not have the requisite knowledge about laws and policies pertaining to DHS. This rationale overlooks the fact that a CFRC would have access to the expertise of a multidisciplinary team, whose members should be able to provide knowledge and advice in this area. The CFRC could also call upon “individuals with specific child death expertise as necessary.”

Second, Dr. Klein stated that a volunteer ad hoc committee could not “facilitate the necessary level of detailed investigation required to fully illuminate the complexities and issues surrounding” the Finn case.

Lastly, he stated that convening a CFRC would result in duplicative work, since the Ombudsman had already undertaken the task of reviewing Natalie's death and the Child Death Review Team would also be reviewing the case. Dr. Klein did not mention that the Ombudsman had advised him that the scope of our office's investigation would depend on whether he convened a CFRC and the extent of its investigation.

Role of the Child Death Review Team

We also looked at whether the Child Death Review Team (CDRT) would review Natalie's death. The CDRT is authorized to help reduce preventable deaths of children under age 18 by identifying unsafe consumer products, unsafe environments, and factors that play a role in accidents, homicides, and suicides.⁶⁴

⁶² IOWA CODE § 135.43(4)(c).

⁶³ IOWA CODE § 135.43(4)(b). Pursuant to Code section 135.43(4)(d), the CFRC would still be subject to restrictions for releasing information covered in section 235A.15(9).

⁶⁴ IOWA ADMIN. CODE r. 641—90.1.

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The CDRT is also charged with promoting the exchange of ideas and information among agencies investigating child deaths, and with submitting an annual report to the Governor and the General Assembly about the causes and manner of child deaths.⁶⁵ By law, the report must include recommendations for preventing child deaths.⁶⁶

The CDRT is composed of 14 official members, including the State Medical Examiner's designee, multiple medical professionals with experience in child death, a law enforcement official, a county attorney, liaisons from seven state agencies, and a liaison from the public at large.⁶⁷

The CDRT's day-to-day work was originally overseen by personnel within the Iowa Department of Public Health.⁶⁸ In 2009, the CDRT's annual budget of \$28,000 was eliminated and coordination of CDRT's work was transferred to the State Medical Examiner. CDRT has not had an operating budget since 2009.⁶⁹ The State Medical Examiner's office has one full-time and two part-time staff members assigned to CDRT activities.⁷⁰

Members of the CDRT are eligible for reimbursement of actual and necessary expenses incurred in the performance of their official duties.⁷¹ But team members do not actually receive any such reimbursements, according to the introduction to CDRT's 2015 annual report (released in 2018). That introduction, written by CDRT Chairperson Dr. Meghan Harris, stated:

It must be noted that at present, this team receives no funding of any kind. Travel, time, and even lunch during each day-long meeting five times each year are paid out of the pockets of the participants or by using minor allocations of time from existing positions. In order to have greater impact and appropriately sustain the ICDRT, the team must be appropriately resourced. This work is too important.

Another problem is the timeframe in which the CDRT conducts its reviews. When Natalie died in 2016, the CDRT had not yet issued the annual reports for 2013, 2014, or 2015. The 2016 and 2017 annual reports have not been completed as of the issuance of this report.

Role of the Polk County Multidisciplinary Team

Another government entity that could have reviewed Natalie's death was the Multidisciplinary Team (MDT) in Polk County. MDTs (mentioned earlier as a resource for the CFRC) are established to assist DHS in conducting child abuse assessments. These teams are required to consist of professionals in the fields of medicine, public health, mental health, social work, child development, education, law, juvenile probation, law enforcement, nursing, and substance abuse counseling. Along with providing consultation in diagnosing child abuse cases, MDTs can issue

⁶⁵ IOWA CODE § 135.43(3)(a).

⁶⁶ IOWA CODE § 135.43(3)(b).

⁶⁷ IOWA CODE § 135.43(2).

⁶⁸ Iowa Office of the State Medical Examiner, *The Mission of the Iowa State Medical Examiner*, page 14. (https://iosme.iowa.gov/sites/default/files/documents/2015/09/history_of_the_iosme_0.pdf).

⁶⁹ The National Center for Fatality Review and Prevention, *Spotlight – Iowa*, (February 2018). (<https://www.ncfrp.org/cdr-programs/u-s-cdr-programs/spotlight-iowa/>).

⁷⁰ *Id.*

⁷¹ IOWA CODE § 135.43(2).

non-binding recommendations to DHS in specific child abuse cases.⁷² MDT members serve without compensation.

Despite containing a wealth of expert knowledge and experience, the MDTs have significant limitations. For instance, they serve in only an advisory function to DHS and the CFRC.⁷³ They do not operate independently from the agency they are investigating, a critical feature of any entity providing administrative oversight. (In contrast, both the Ombudsman and the CFRC are independent of DHS.)

MDTs are also limited in the scope of their review, as they do not have access to rejected intakes – child abuse reports which were not accepted for assessment.⁷⁴ Nor can MDTs issue public reports on their findings; their confidential reports are submitted only to DHS.

Role of the child protection services citizen review panels

We also considered the role of the child protection services citizen review panels (CPS panels). DHS is required to establish at least three CPS panels, with at least one each at the state level, multicounty level, and county level.⁷⁵ The CPS panels are required to identify strengths and weaknesses in the child protective services system and provide recommendations for improvements.

More specifically, the CPS panels are charged with determining whether DHS is complying with state and federal law, as well as “any other criteria that the panel considers important to ensure the protection of children, including ... a review of child fatalities and near fatalities.”⁷⁶ None of the CPS panels conducted a review related to Natalie’s death.

The CPS panels are required to include a “multidisciplinary team of volunteer members,” including members who possess knowledge and skills related to the diagnosis, assessments, and disposition of child abuse cases, and who have expertise in the prevention and treatment of child abuse.⁷⁷ Members include a broad representation of the community, including professionals in the fields of medicine, nursing, social work, child development, and law enforcement.

Each CPS panel releases a public report annually containing a summary of the panel’s activities.⁷⁸ Though members of the panels have access to confidential DHS child abuse records, this information is held confidential and is not released as part of the public reports.

⁷² IOWA CODE § 232.71B(11). The DHS is required by law to establish a multidisciplinary team when there are more than 50 child abuse reports made per year in a county or multicounty area.

⁷³ IOWA ADMIN. CODE r. 441—175.36(1). (“The team shall be consulted solely for the purpose of assisting the department in the child abuse assessment and diagnosis of child abuse cases.”)

⁷⁴ IOWA ADMIN. CODE r. 441—175.36. (“Rejected intakes shall not be shared with multidisciplinary teams since the rejected intakes are not considered to be child abuse information.”)

⁷⁵ IOWA ADMIN. CODE r. 441—175.43(1). CPS panels currently operating are the Child Protection Council (state level), the North Iowa Domestic and Sexual Abuse Community Coalition/Cerro Gordo County Citizens Review Panel (multicounty level), and the Woodbury County Citizen Review Panel (county level).

⁷⁶ IOWA ADMIN. CODE r. 441—175.43(4).

⁷⁷ IOWA ADMIN. CODE r. 441—175.43(2).

⁷⁸ IOWA ADMIN. CODE r. 441—175.43(8).

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Based on our review, we believe the purpose and functionality of the CPS citizen review panels is clearly inadequate to perform in-depth investigations that are required for comprehensive reviews of child fatalities.

Conclusion and Legislative notification

To our knowledge, our office is the only independent entity that initiated and completed an in-depth review of DHS's actions involving the Finn family. The State Medical Examiner declined to convene an ad hoc CFRC while the other oversight entities we identified had significant limitations in their resources and authority.

The Ombudsman made the decision to initiate this investigation because someone needed to.

By default, the Ombudsman was the only entity capable of conducting an independent systemic review of DHS's actions. This begs the question: What are the Legislature's expectations of these other entities – particularly the CFRC – to review child fatalities? The Ombudsman made the decision to initiate this investigation because someone needed to.

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.

OVERVIEW OF THE SHELBY DUIS CASE

Tragic cases of child abuse often serve as an impetus for enhanced child protection efforts and system reform. The beating death of two-year-old Shelby Duis in January 2000 was such an event, leading to several child protection reforms and increased investment in child abuse prevention....

Reforms have followed other high-profile child abuse cases, such as, more recently, the Sandusky/Penn State scandal. These responses have made significant strides in better protecting children and preventing child abuse. Creating a public will to protect children and prevent their abuse should not, however, depend on these regretful public incidents.

December 30, 2013, press release by Prevent Child Abuse Iowa

To understand how the Finn case fits into the bigger picture regarding DHS's child welfare services, we believe it is important to look back at the last high-profile child death case the Ombudsman investigated 16 years before Natalie died.

Shelby Duis was found dead at her Spirit Lake home on January 4, 2000. She was two years and nine months old. An autopsy found evidence of multiple blunt force injuries, some acute and others that were inflicted several weeks and months before Shelby's death.

Many people in the Spirit Lake area and around the state were outraged. Some of the anger was directed at DHS. Several individuals said they had repeatedly told DHS that they suspected Shelby was being abused. DHS conducted an internal review to address the concerns expressed by those individuals and to identify any issues related to policy compliance and practice. DHS subsequently issued a report which concluded, "From the review of Shelby's death, we determined that the policies critical to her safety were followed."

At the request of three members of the Iowa Senate, the Ombudsman opened an investigation into DHS's handling of the child abuse reports it received about Shelby. Our investigation found problems with DHS's procedures for receiving, handling, and investigating child abuse reports

Based on our investigative findings and conclusions, the Ombudsman submitted 23 recommendations to DHS to improve the agency's responses to child abuse reports. The most significant recommendation was for DHS to create a centralized intake unit for receiving child abuse reports.

In her written response to the Ombudsman's report, then-DHS Director Jessie Rasmussen wrote: "We must learn from this tragedy. We must act on the insights and recommendations from the Ombudsman's Report as well as recommendations from others."

She later added, "While we may not fully agree with every conclusion the Ombudsman made, it is clear that we do need to make changes to improve our child protective system."

THE DEATH OF SABRINA RAY AND THE HIRING OF AN OUTSIDE REVIEWER

Our investigation of Natalie Finn's death was underway when 16-year-old Sabrina Ray was found dead in her family's Perry home on May 12, 2017.⁷⁹ A DHS official acknowledged to the Ombudsman that the Ray case had some similarities to the Finn case. DHS officials announced they were hiring an outside expert to review DHS's performance and make recommendations on how it could strengthen its practices and support its staff to keep children safe from abuse and neglect.⁸⁰

⁷⁹ The Ombudsman's office has a separate ongoing investigation of the death of Sabrina Ray.

⁸⁰ 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.

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At that time, it was unclear whether the outside reviewer would examine the Finn case and/or the Ray case. DHS officials announced on June 5, 2017, that they were hiring 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.”⁸¹

Shortly thereafter, we received clarification from a DHS official that CWG would not be reviewing DHS’s handling of the Finn or Ray cases.

CWG subsequently issued a report titled “Initial Targeted Child Welfare Review” on December 22, 2017. 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 2017⁸²), a seasoned and dedicated workforce, and committed community partners and families.

Foxhoven’s employment as DHS director ended two years later on June 17, 2019.

We will address the strain on staffing levels and recent employee turnover later in the report.

⁸¹ DHS’s press release, *DHS Engages National Expert for Child Welfare Review*, June 5, 2017.

⁸² 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.

Four child abuse reports: 2005-2012

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-hour-a-day, seven-day-a-week basis.⁸³ Most child abuse reports are received through calls to the toll-free Child Abuse Hotline operated by DHS.⁸⁴ When DHS receives a child abuse report, staff conducts an intake to determine if the report should be accepted or rejected. DHS's internal investigation stated in part:

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.⁸⁵

The Centralized Services Intake Unit (CSIU) accepts child abuse reports Monday through Friday, 8:00 a.m. to 4:30 p.m. Although CSIU is open for only 42½ hours in a typical week, the unit on average handles three out of every four child abuse reports.⁸⁶ 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.⁸⁷ On average, 180 of those calls are intakes for child abuse, Child in Need of Assistance (CINA), and Dependent Adult Abuse (DAA).⁸⁸ 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.⁸⁹

⁸³ IOWA CODE § 235A.14(3).

⁸⁴ Child abuse reports can also be received by local DHS offices and the central abuse registry, but DHS said it is “a rare occurrence.”

⁸⁵ DHS's Executive Summary, page 2.

⁸⁶ DHS, *Centralized SA CY 2018-2019 Unit Strategic Plan*.

⁸⁷ *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.

⁸⁸ *Id.*

⁸⁹ CSIU's *Operational Manual*, page 10.

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According to DHS, all phone lines answered by CSIU intake workers are recorded and stored electronically.⁹⁰ 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.”⁹¹

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 injury or an immediate threat to safety); or 12 hours (where there is no high-risk injury and no immediate threat to the child).

Calls to the Child Abuse Hotline outside of normal CSIU business hours are answered by staff at the State Training School (STS) in Eldora.⁹² 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, the STS worker contacts the field worker who is on call for 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.

A child abuse report must meet three criteria to be accepted for assessment:

1. The alleged victim is a child, defined as any person under the age of eighteen years,⁹³ and
2. The alleged perpetrator is a caretaker,⁹⁴ defined as a person responsible for the care of the child,⁹⁵ and
3. The alleged incident falls within the statutory definition of child abuse.⁹⁶

2005/2006 ACCEPTED INTAKE AND ASSESSMENT (OUTCOME UNKNOWN)

We became aware of a purported child abuse report through the comment section of a 2016 media story following Natalie’s death. We reached out to the commenter, , who told us she worked at the Happy Time Daycare in 2005 or 2006, when Natalie and her three siblings – ranging in age from 3 to 5 years old – attended the center. The daycare worker recalled a couple of interactions with Nicole, including one in which Nicole told her to not hold Natalie’s sister, then age 3, because “she is not a baby.” She also recalled Nicole directing daycare staff not to give her children water when they were thirsty, even on hot days, because they could get “water poisoning.” Nicole explained that it was because the children did not know when to stop drinking.

⁹⁰ November 2, 2017, letter of response from DHS.

⁹¹ November 2, 2017, letter of response from DHS.

⁹² The STS is a residential facility for male juvenile offenders that is managed by DHS.

⁹³ IOWA CODE § 232.68(1).

⁹⁴ IOWA ADMIN. CODE r. 441—175.21.

⁹⁵ 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.

⁹⁶ IOWA ADMIN. CODE r. 441—175.24(1).

In a separate incident, the daycare worker told us that she made a child abuse report to DHS after she saw ligature marks on one of the children's neck. The child told her that Nicole had caused it. Based on the daycare worker's description of what occurred next, it appears DHS accepted the report for an assessment. She said a DHS worker named "Jody" came to the daycare and asked her and other staff questions about XXXX. According to the daycare worker, when her boss told Nicole that the woman had made the child abuse report, Nicole pulled her children out of the daycare the next day. The daycare worker did not know what resulted from her abuse report.

DHS did not have records of any reports made by the daycare worker on the Finn children.

2008 ACCEPTED INTAKE AND ASSESSMENT (OUTCOME UNKNOWN)

While reviewing a 2012 intake report, we learned about a prior child abuse assessment involving the Finn family from 2008. DHS informed us that this intake was accepted on April 10, 2008, and an assessment was completed on May 8, 2008. Nicole Finn was the alleged perpetrator and her children, Natalie, XXXX, and XXXX, were identified as alleged victims. At that time, they would have been 7 years old, 6 years old, and 5 years old, respectively.

DHS officials said that all records connected with this intake and assessment were expunged in May 2013, pursuant to departmental administrative rules limiting retention of most assessment records to five years.⁹⁷ As a result, no other information is available about either the intake or the assessment, including who reported it, the type of abuse that was alleged, and the outcome of the assessment.

2009 CHILD ABUSE REPORT BY NATALIE'S FOURTH-GRADE TEACHER

We contacted a teacher in the West Des Moines school district after another school employee told us that the teacher might have previously filed a child abuse report about Natalie. The teacher told us that he made a child abuse report in November or December of 2009, when Natalie was a student in his fourth-grade class. The teacher said that during the school year, Natalie was often hungry and sometimes stole candy from his desk.

According to the teacher, he reported to DHS that Natalie told him she was confined alone in a room for several hours every day and she was not allowed to eat during those times. "There was a time where she said that she was put into a closet," the teacher said. "She had shown marks on her arm that I remember definitely seeing. With the pushing and shoving of not wanting to go into the room." He later added, "I do remember her fear of leaving that room, and there's a consequence for her leaving that room."

The teacher described to us the marks he saw on Natalie's arm as scratches and red "grabbing marks." When he called DHS, he said, "My number one concern was that image of her retelling that story of her sitting in a bleak room with a chair for hours. And then obviously the marks to back it up with."

⁹⁷ IOWA ADMIN. CODE r. 441—175.32.

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The teacher told us he did not recall receiving any kind of written notice or other communication from DHS in response to his report.⁹⁸ He said the DHS employee who took his call indicated his report was not sufficient to warrant an assessment.

DHS officials told us that they have no record of any such intake. “Any intake received in 2009 would be expunged from our system,” they stated. “In accordance with Iowa law, not only would a copy of it be deleted from our electronic system, but any corresponding paper file would be destroyed as well.”⁹⁹

2012 ACCEPTED INTAKE AND ASSESSMENT (NOT CONFIRMED)

DHS received a child abuse report from a nurse at Hillside Elementary School on February 10, 2012, concerning one of the Finn children. According to the intake document, the reporter alleged that Nicole Finn, had pulled the child’s hair that morning and left scratch marks and some light bruising. The child had told the reporter that Nicole did not think the child was getting ready for school fast enough. The reporter stated both parents seemed to utilize hair pulling with the children.

The intake was accepted for a child abuse assessment. According to the Child Protective Assessment Summary (Assessment Summary), the child told the field worker in an interview at school that they had never been injured by Nicole before and that the child felt safe at home. The field worker also interviewed the school principal, who had no significant safety concerns. The Assessment Summary indicated that the incident in question occurred shortly after Nicole told the child to get ready for school before eating breakfast. Nicole told the field worker that the child was having a tantrum when Nicole intervened and she may have accidentally scratched the child.

The field worker determined the child was safe and stated that Nicole did not want to participate in voluntary support services. The Assessment Summary concluded that the injury was accidental and Nicole could not have reasonably foreseen that her actions would result in injury.

ANALYSIS

Based on our review of the 2012 intake and assessment, we do not have concerns with how this intake and assessment were handled. It is worth noting, however, that Nicole was withholding food, specifically breakfast, to gain compliance.

We believe the daycare worker made a child abuse report in 2005 or 2006, given the level of detail she shared with our office about her interactions with Nicole and the Finn children. Her experience also echoes behavior described in subsequent abuse reports involving Nicole restricting her children’s access to water and pulling a child from school after school officials

⁹⁸ According to DHS’s Employees’ Manual, Title 17, Chapter A, page 5, DHS must send the reporter a written notice of the intake decision within five days of receiving a report. This policy was adopted on September 1, 2006, and would have been in effect at the time the teacher said he made an abuse report about Natalie.

⁹⁹ Although current DHS policy calls for rejected intakes to be retained for three years, rejected intakes as of late 2009 were to be retained for only six months. If in fact the teacher made such a child abuse report to DHS in late 2009, and if it was rejected, any records of that intake would have been destroyed by around June 2010. It is worth noting that all of this would have preceded the June 28, 2010, opening of DHS’s centralized intake unit.

expressed concern. Unfortunately, we are not able to reach any findings on how DHS handled this intake as any records from that time had been destroyed under DHS’s record retention policy.

We similarly found the teacher’s account of his interactions with Natalie and his 2009 report to DHS to be very credible. However, we are again unable to reach any conclusions on DHS’s response because any records of the case had been destroyed pursuant to policy.

“The stories that she told me, I mean, those will forever be ingrained in my head,” the teacher told us. “I mean, I remember every word of it.”

Prior to March 1, 2010, DHS was only required to keep rejected intakes for six months. After that date, the retention period was expanded to three years.¹⁰⁰ Keeping rejected intakes allows that information to be considered as part of future intake decisions and assessments.¹⁰¹ This ensures child protective staff “are thinking comprehensively about the child’s safety and considering all information known” to DHS.¹⁰²

Accepted intakes are kept based on the finding of the assessment. “Confirmed” and “not confirmed” child abuse assessments are to be retained for five years, or five years from the date of closure of the service record, whichever occurs later.¹⁰³ Assessment summaries of “founded” child abuse reports are kept on the Child Abuse Registry for ten years (or ten years after the most recent confirmed abuse when the same victim or person responsible is placed on the Registry).¹⁰⁴

It is unfortunate that we could not make any findings or conclusions on the handling of the child abuse reports made in 2009 and before considering the lasting impact they had on the teacher and the daycare worker. “The stories that she told me, I mean, those will forever be ingrained in my head,” the teacher told us. “I mean, I remember every word of it.”

The teacher said that after making his report to DHS, he continued to receive similar reports from Natalie about how she was treated at home. He said Natalie exhibited signs of being extremely hungry “all the way up to the end of the year.” Because his report was rejected, the teacher said he initially developed a feeling of “distrust and animosity” with DHS. “My last resort was DHS,” he told us. “I thought they’d come in here on a white stallion and solve the problems.”

CONCLUSIONS AND RECOMMENDATION

Our investigation has brought to light the potential problem of DHS’s limited record-retention policy. Because records from the 2008 accepted intake and assessment were not available, we were unable to assess whether that report included any food-related allegations as later reports would. A daycare worker stated that she reported in 2005 or 2006 ligature marks on XXXX’s neck – which on its face appears similar to the 2012 report made about XXXX’s injuries – but

¹⁰⁰ IOWA ADMIN. CODE r. 441—175.24(4)(c).

¹⁰¹ DHS’s Employees’ Manual, Title 17, Chapter A(3), page 24.

¹⁰² *Id.*

¹⁰³ IOWA ADMIN. CODE r. 441—175.32(3)(b) and 175.32(4)(b).

¹⁰⁴ DHS, *Notice of Child Abuse Assessment: Founded*, 470-3243 (Rev. 3/17)

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we were unable to determine if any information was shared in the intake or assessment reports about Nicole restricting water access for the children. Natalie’s fourth-grade teacher says he told DHS that in 2009 Natalie was stealing food at school and was forcibly confined to her bedroom. These early cases 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.

Older records are equally important to an outside reviewer, such as the Ombudsman. The absence of records prevents us from reaching any firm conclusion on the appropriateness of DHS’s responses to the 2005, 2008, and 2009 reports.

These early cases 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.

Vern Armstrong, Administrator of DHS’s Division of Field Operations, told us that maintaining everything in the digital age costs money and resources. We would argue that any potential cost is offset by the benefit of identifying patterns of child abuse. Record-retention policies in 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.

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.”¹⁰⁵

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.¹⁰⁶ DCS retains substantiated case files indefinitely, unless expungement of the record is ordered by a court or administrative law judge.¹⁰⁷

The Ombudsman believes 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.

¹⁰⁵ <http://www.gencourt.state.nh.us/rsa/html/XII/169-C/169-C-35-a.htm>.

¹⁰⁶ <https://www.in.gov/dcs/files/2.13%20Expungement%20of%20Records.pdf>.

¹⁰⁷ Indiana’s policy appears to make no mention of rejected intakes, or how long the records of rejected intakes must be retained.

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.**

Five child abuse reports: November 2015 – May 2016

Beginning in November 2015, DHS received 10 child abuse reports about the Finn children over an 11-month period. Of those 10 reports, 8 were rejected and 2 were accepted for assessment. In this section we will discuss the first five of those ten reports.

NOVEMBER 18, 2015, REJECTED INTAKE

DHS received a child abuse report regarding Natalie (then age 15) on November 18, 2015, from the principal at Walnut Creek Campus, a West Des Moines Community Schools alternative high school. The intake was handled by an intake worker at CSIU at the time.

The audio recording for this call shows the principal reported that Natalie was “very thin,” adding, “So Mom is saying there’s plenty of food at home, she’s just choosing not to eat it, versus the girl seems like she’s starving here.” None of those statements were documented in the intake report.

The principal also reported that Natalie was not showering or changing her clothes daily, was sharing a bedroom with her sister and brother, was hoarding food, and her shoes were falling apart. When school employees and other people tried to help, Nicole would become defensive and tell people that Natalie was just manipulating them. The principal alleged that Nicole was making Natalie avoid the people that had been trying to help her. Natalie was fearful that her mother would find out what she was doing.

The principal also shared that the family was running an animal shelter out of the home with 30 animals, and it was unknown if it was a clean environment for the children. When Natalie was asked if she had eaten dinner, she always said she got into trouble and she was not allowed to eat.

Late in the call, when asked if there were concerns for Natalie’s siblings, the principal replied that she thought another principal was going to call about that.

The intake document identified the allegation as “Denial of Critical Care, Failure to Provide Proper Supervision.”

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. Amanda Kuhl, a Social Work Supervisor (SWS), subsequently reviewed the intake report and made the final decision to reject it.

In a section of the intake report titled “Rejection Reason,” the intake worker wrote, “No information the child has been denied basic needs or neglected her basic needs.”

Twenty-eight minutes elapsed between the time the call ended and the reject decision.

FEBRUARY 5, 2016, REJECTED INTAKE

DHS received a child abuse report on February 5, 2016, from the school nurse at Walnut Creek Campus. She reported numerous concerns about Natalie's health, physical appearance, home conditions, and Nicole's controlling personality.

The audio recording for this call shows the school nurse reported that Natalie was underweight and malnourished, having not eaten much food at home for the last few weeks.¹⁰⁸ The school nurse observed that Natalie's "face is gaunt," and her "clothes are hanging on her." Natalie would ask for food from school staff and other students, and she would stop by the school nurse's office several times a day to ask for food. Natalie told her that she was 20 pounds underweight according to her doctor. The school nurse informed DHS that Natalie weighed 108½ pounds that day, at a height of 5'4" or 5'5", while Natalie reported that she weighed 120 pounds just a couple of months prior.

The school nurse said Natalie would wear the same clothes daily, would not bathe, and had body odor and greasy hair. She had offered her clothes, but Natalie said she was not allowed to take anything home, as it would make the family look poor and her mom would be livid. The school nurse also recounted how in the fall, Natalie wore shoes with holes in them. Another student brought shoes in for Natalie that she took home, but Nicole made her return them. "The story is the Mom says she has other shoes, but she continues to wear these shoes with big holes in them," the school nurse said.

In addition, she relayed that Natalie said, "We are closed in our room. I have to ask her for everything." If Natalie wanted something, Nicole would come to the door and Natalie would ask for what she wanted. While they had plenty of food in the home, Natalie would not get any if she did not ask for it. "Sometimes I just don't ask," Natalie had told the school nurse. At one point Natalie had said, in front of her mother, "I'm in my room most of the time."

The school nurse inferred that Nicole may have had mental-health issues, describing her as very controlling and manipulative. She said Nicole had called Natalie a liar and thief, limited Natalie's contact with school staff, and accused Natalie of being manipulative.

According to the intake report, the intake worker consulted SWS Mike Allison, who decided to reject the intake because there was insufficient reason to suspect the child was denied adequate care.¹⁰⁹ The intake worker wrote that there was no indication Nicole was withholding food. The

¹⁰⁸ The intake report stated, "For a couple of weeks, Natalie hasn't eaten anything except at school.... Last weekend, Natalie only had one meal on Saturday and no meals on Sunday."

¹⁰⁹ According to DHS's Executive Summary, pages 3-4, Allison "took time to research policy and he checked a body mass index (BMI) chart for Natalie's age, which indicated her weight was in range. His intent was to support a decision to accept, but instead his research led him to the decision to reject. He made a judgment call based on the BMI chart indicating Natalie's weight was within normal range and the information that there was food in the home." The Executive Summary added that Allison "was subject to a personnel investigation and was formally coached and counseled regarding the basic premise that in order to accept a report, all that is required for acceptance is a child victim, a caretaker and an allegation that, if true, would result in founded abuse. Intake is not supposed to attempt to determine if abuse has occurred.... If the decision was open for enough questioning, Intake should have accepted the report for assessment."

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intake worker also noted that Natalie was 16 years old and knew she could ask for food but chose not to. "It is not believed Natalie has any skin breakdown or infections."

Forty-six minutes elapsed between the time the call ended and the reject decision.

APRIL 19, 2016, REJECTED INTAKE

DHS received a child abuse report on April 19, 2016, from the Student Services Coordinator at Walnut Creek Campus.

The audio recording from this call shows that the Student Services Coordinator (SSC) reported that Natalie said her mother slapped her and locked her out of the house the day before. Natalie then left and went to a friend's home. Nicole and her ex-husband, Joe, reported Natalie as a runaway that night. Natalie showed up at school the next morning.

The SSC did not observe any marks and Natalie did not report any injuries. Natalie told him that she was afraid to go home, but later said she was okay going home since her Dad was going to be there. The SSC also reported that Natalie had talked about being spanked with a belt in the past few weeks and not getting enough food at home.

According to the intake report, the intake worker consulted SW4 Oberbroeckling, who made the preliminary decision to reject the intake. SWS Allison subsequently reviewed the intake and made the final decision to reject it. The logic supporting the decision to reject was that there were no injuries, the parents acted appropriately by calling police when Natalie ran away, and there was insufficient information to infer the parents were failing to provide adequate nutrition.

The intake report indicates that 20 minutes elapsed between the time the call ended and the reject decision.

MAY 27, 2016, REJECTED INTAKE

DHS received a child abuse report on May 27, 2016, from an attendance caseworker at Walnut Creek Campus. According to the intake report, the attendance caseworker said a neighbor who "lives just up the block from Natalie" had come to the school to report concerns about Natalie. "Natalie stopped at her house and said that she was just starving and hasn't had any food and she said that she waited til Mom fell asleep and she snuck out of the house to get some food because she didn't have anything," the attendance caseworker said, adding "this is not the first time that she has done this."

Those statements were documented in the intake report as follows: "A woman came to school and told concerns, she lives near the family. Natalie told this women (sic) that she was hungry and mom did not have any food." Among other things, Natalie's purported statement that she "was just starving" was not documented in the intake report.

After Natalie left the woman's house, the attendance caseworker said, the woman drove away and saw Natalie "come out of another lady's house with more food." Those statements also were not documented in the intake report. Asked whether Natalie looked malnourished, the

attendance caseworker replied, “Yes, she does, she looks very thin.” The intake report stated, “Natalie is thin,” failing to document the reporter’s statement that Natalie looked malnourished.

The attendance caseworker said in the audio recording of this call that she called DHS because the neighbor did not want to make the call herself. Although she said the woman was the parent of another student, the attendance caseworker did not identify the woman, nor did the intake worker ask for the woman’s identity or contact information.

When we interviewed the attendance caseworker, she told us that the woman she had referred to was a neighbor who had befriended Natalie. She told us that after she made her report to DHS, she called the neighbor “and I encouraged her to make the phone call too.” She told us that the neighbor indicated she did not want to call DHS because she did not want Natalie’s mother to be “mad at her for getting involved or sticking her nose in the business of her child.”

When we interviewed the neighbor, she told us that she *did* make a child abuse report to DHS about Natalie. The neighbor said she made her report around Memorial Day weekend in 2016, which would have been immediately after the attendance caseworker’s report. However, DHS officials told us they have no record of receiving a child abuse report from that neighbor about the Finn family.¹¹⁰

After the call, the intake worker consulted Social Work Supervisor (SWS) Ty Noard, who decided to reject the intake because the information was not first-hand knowledge, the child was reportedly in therapy, and she was hoarding food so she was believed to be eating.

Eleven minutes elapsed between the time the call ended and the reject decision.

MAY 31, 2016, ACCEPTED INTAKE

On May 31, 2016, the West Des Moines Police Department (WDMPD) received two separate “welfare check” calls about children who lived on 15th Street. Officers were dispatched in response to both calls, which were about five hours apart.

The first call was received at 10:03 a.m. from an employee at the Git-N-Go store at 1325 Grand Avenue. According to a WDMPD dispatch log, the caller reported he was concerned about the welfare of two teenage girls who had just left the store. He said the girls appeared to be homeless and one of them was limping.

Patrol Officer Jason Hatcher responded to the call and spoke to the girls, who told him they lived on 15th Street and were home schooled. They explained to Officer Hatcher that they had just woken up, which explained their appearance. Officer Hatcher later reported that other than needing to wash their hair, they appeared fine. There is no indication that Officer Hatcher identified the two girls or their exact home address.

¹¹⁰ We made additional efforts to determine whether the neighbor made a child abuse report to DHS about Natalie. First, we obtained and reviewed her phone records to determine whether an outbound call was made to the Child Abuse Hotline or two local phone numbers which can be routed to CSIU. We found none of these numbers in any of the neighbor’s outgoing calls both on and around Memorial Day Weekend 2016. We also contacted the State Training School (STS) in Eldora to determine whether an after-hours call was received from the neighbor. STS officials told us they found no record of such a call by the neighbor.

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WDMPD received the second call at 3:29 p.m. that same day from the neighbor who had befriended Natalie, expressing concern about the Finn children, who lived at 805 15th Street. According to a call information report, the neighbor reported that one of the Finn children went to her house to get food often, and all of the kids had blisters on their feet.¹¹¹ The neighbor did not believe the children were going to school. They never used to play outside, but now they were outside all of the time. The neighbor also reported that Natalie said her Mom had locked her in her room. She mentioned that the children wore the same clothes several days in a row and did not shower often.

Officer Matthew Granzow was dispatched to the Finn residence at 3:34 p.m. In a summary that he added to the call information report, he wrote that it sounded like they were the same kids that appeared homeless at the Git-N-Go earlier in the day.

Later that day, Officer Granzow opened case file 16-2613 and wrote the following incident report:

On 5-31-2016, officers were dispatched to 805 15th Street reference a welfare check. The reporting party stated that there are three children that range from 14-16 years old that live at this address. The reporting party stated that she lives down the street and recently one of the teenage girls has been coming to her house asking for food. The girl appears un kept (sic) and is seen wearing the same clothes for days at a time.

Officer Barry Graham and I arrived at the house at the same time. While approaching the house I could see that someone was looking out the front window. I knocked on the door multiple times and nobody answered. While standing out the door (sic) someone was peeking around the curtains. We stood at the front door for a couple of minutes and nobody answered.

I called and spoke with the reporting party.... [She] advised that one of the teenage girls attends school with her son at Walnut Creek. A couple of weeks ago the girl, who [the neighbor] identified as Natalie Finn, started coming to her house and asking for food and money. She showed up almost every day for a week asking for food and even asked to take extra food home for her sister. [The neighbor's] son reported that while she was at school Natalie would ask other classmates for money and food. Natalie would wear the same clothes for multiple days and had very bad body odor. On one occasion Natalie told [the neighbor] that she does not have shoes and because of that had two blisters on the bottom of her feet. [The neighbor] saw the blisters and said they were large. On that day Natalie was wearing flip-flops, but other days [the neighbor] saw Natalie wearing shoes. Natalie asked [the neighbor] for gauze to wrap up her blisters. On another occasion Natalie reported to [the neighbor] that she was locked in her bedroom by her mother because one of the pets urinated on the floor. [The neighbor] states that Natalie appears skinnier than average.

¹¹¹A few minutes later, the neighbor told the responding officer that she had seen blisters on Natalie's feet, but she made no similar statements about Natalie's siblings. When we interviewed the neighbor, she said she had seen blisters only on Natalie's feet.

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[The neighbor] reported seeing Natalie walking out of the first house north of Git-N-Go with food in her hands.

[The neighbor] does not know the age of the other kids but thinks that they may be in the area of 14 years old. There is one boy and another girl that live at the house. [The neighbor] believes the mother's name is Nikki Finn.

Based on the information from the neighbor and Officer Hatcher, Officer Granzow called DHS's Child Abuse Hotline that evening to make a report. Although Officer Hatcher had not identified the two children he encountered, Officer Granzow decided to include that incident in his report to DHS.

Because Officer Granzow called the Child Abuse Hotline outside of CSIU's regular business hours (8 a.m. to 4:30 p.m.), his call was handled a field worker who was assigned to handle after-hours child abuse reports received that night from Polk County.

The intake report recounted much of the same information contained in Officer Granzow's incident report, including Natalie asking for food from others, the mother locking Natalie in her room, and the report that the girls looked and dressed like they were homeless. The intake report noted that the police could not get anyone at the children's home to open the door.

The intake report also contained information from prior DHS intake reports:

There are three rejected intakes in 2016 stating Natalie said she is not fed enough at home. Lookups show they are adopted and receive subsidy. Natalie is stated to have mental health issues but the school has not received calls back from therapy. Natalie is stated to be severely underweight. Pror (sic) rejects state Mom is controlling and does not let kids have much contact or help from others.

The field worker who handled this intake subsequently consulted a field supervisor, Mark Chappelle. She would later tell us that she recommended accepting the intake for two main reasons. The first was her discovery that this was the fourth child abuse report in less than four months alleging that Natalie was not getting enough food at home. The field worker said the second main reason she recommended accepting the intake was her familiarity with the reporter in the May 27 rejected intake, noting that the attendance caseworker "doesn't report things lightly."

... this was the fourth child abuse report in less than four months alleging that Natalie was not getting enough food at home.

Chappelle decided to accept the intake as a family assessment with a 72-hour response time to observe the children. The intake report shows that the assessment was assigned to then-field worker Amy Sacco at 9 p.m. that same evening. All four children living in the Finn residence at that time were identified as "child subjects."

Ninety-five minutes elapsed between the time the call ended and the accept decision.

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ANALYSIS

All calls answered by CSIU intake workers are recorded and stored electronically. Our office obtained and reviewed the recordings for the first four of these intakes. There are no recordings of after-hours child abuse calls such as the May 31, 2016, intake.

Our office identified a number of concerns with how the five child abuse reports received between November 2015 and May 2016 were handled. The areas of concern included intake workers failing to complete thorough and accurate intake reports, failing to collect information on collateral witnesses, and failing to review prior intakes – all of which run contrary to DHS policy. We also believe three of the four rejected intakes should have been accepted for assessment.

Thoroughness and accuracy

An integral part of the intake worker’s job is to produce a complete and accurate record of the reporter’s understanding of the alleged abuse and the surrounding circumstances. The clearest enunciation of this standard is contained in CSIU’s “Intake Evaluation Tool,” which indicates 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.¹¹²

Intake workers are also instructed to record necessary information and discern between significant and extraneous information.¹¹³ During a discussion about this policy, Service Area Manager Lori Lipscomb¹¹⁴ 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 a trained intake worker can, within reason.

However, we found multiple instances where significant information was shared by reporters but was not documented in intake reports.

The following table compares statements made by the principal during the November 2015 phone call and what was captured in the intake report:

November 18, 2015, Intake Call from Principal at Walnut Creek Campus

Principal’s statement	Intake report
“The girl is very thin. So Mom is saying there’s plenty of food at home, she’s just choosing not to eat it, versus the girl seems like she’s starving here. ” (Emphasis added.)	<i>This statement was not documented.</i>

¹¹² DHS’s Employees’ Manual, Title 17, Chapter A(1), page 6.

¹¹³ DHS, *Child Abuse – A Guide for Mandatory Reporters Guide*, July 2019, page 32.

¹¹⁴ Lipscomb is the Service Area Manager of the Centralized Services Area, which includes CSIU.

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<p>“... when the staff member asked her (Natalie) why she hasn’t eaten dinner she always says she got in trouble and therefore she wasn’t allowed to eat.” (Emphasis added.)</p>	<p>“When Natalie is asked if she has eaten dinner she says she got into trouble and she was not allowed to eat.”¹¹⁵</p>
<p>“I think probably Mom has some mental health issues and I don’t know if that’s a reportable thing. Like, I don’t know if Mom’s getting support, but it’s very strange behavior. And Natalie will convey, you know, ‘I’m a liar, I can’t be trusted.’ I mean it just seems like she’s been programmed to say these messages, and it’s just bizarre.”</p>	<p><i>This statement was not documented.</i></p>
<p>“I spoke with a principal at another school so I think she’ll be calling too about concerns they have for another student as far as just being well kept, showering, wears the same clothes over and over.... I think the other principal’s going to talk about [safety concerns].”</p>	<p><i>This statement was not documented.</i></p>
<p>“They are running some sort of animal rescue situation out of their home and I don’t know how many animals are in the home.... I think there might be like many animals, like 30 animals. I don’t know if this family has the means to take care of animals and children. I don’t know if it’s a clean environment....”</p> <p>“Cleanly environment is really the concern, you know, because the kids are coming unkept to school. I don’t know if the home is, you know, filthy with all these animals.”</p>	<p>“They are running an animal rescue out of the home. There are like 30 animals in the home and it is unknown if it is a clean environment for the animals.” (Emphasis added.)</p>

The intake report omitted several important elements of the principal’s report relevant to child abuse. This included her statement that “Natalie was very thin” and “seems like she’s starving here;” that access to food at home was an ongoing issue for Natalie; her mother’s alleged mental-health issues; and whether the conditions of the home environment were impacting the children. We believe these omissions contributed to the incorrect decision to reject this intake.¹¹⁶ (Later in this section, we will discuss the decisions to reject or accept these intakes.)

¹¹⁵ DHS’s Executive Summary incorrectly described the reporter’s statement as a one-time event. “The reporter indicated that at one time, Natalie had been asked if she had eaten dinner and Natalie said she had gotten into trouble and had not been allowed to eat.” (Page 3).

¹¹⁶ According to DHS’s Executive Summary, page 3, agency officials determined that the intake worker “could have asked probing questions of the reporter to better clarify some of her statements” and was formally counseled.

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We found similar problems with the February 2016 intake, but to a much lesser extent. Overall, we were impressed with the accuracy by which the intake worker documented the school nurse's statements. However, we do have some observations about a few details that were missed:

February 5, 2016, Intake Call from school nurse

School nurse's statement	Intake report
"I think there's a lot of manipulation and neglect and emotional abuse going on there."	<i>This statement was not documented.</i>
"Another school expressed concern and so Mom pulled the kid out of the school and started home schooling her. And I know that's a huge concern for us here, that we get too close and Mom's going to pull her and home school her, and then nobody's going to know what's going on. " (Emphasis added.)	"Mom pulled Natalie's sister out when the school had concerns for her."
"(Natalie) did have shoes this fall that had holes in them, and we tried to get her other shoes. Another student ... brought shoes for her. And she – I think the girl took them home and had to return them. Her mother said she didn't need them, she had other shoes. The story is the mom says she has other shoes, but she continues to wear these shoes with big holes in them. " (Emphasis added.)	"In the fall, child had shoes with holes in it. Another student bought shoes for child. Child took them home, but had to return them."

The first two reporters both described Nicole as allegedly controlling and manipulative. The lack of documentation of this information, in combination with the school nurse's statement that Natalie was continuing to wear shoes with "big holes," may have impacted the decision to reject the intake.

The April 19 intake report represented the most accurate and thorough of the Finn intakes and the intake was appropriately rejected. Unfortunately, the same could not be said of the May 27 intake, in which an attendance caseworker relayed information she had received from the parent of a student.

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May 27, 2016, Intake Call from attendance caseworker

Attendance caseworker’s statement	Intake report
<p>“... (I)t was a parent of another student who shared with me something that she just witnessed herself but she is too – she doesn’t want to make the call herself.... (T)his mother who came in to report this lives just up the block from Natalie.” [In response to a question from the intake worker, the attendance caseworker said her conversation with the woman occurred “about an hour ago.”] (Emphasis added.)</p>	<p>“A woman came to school and told concerns, she lives near the family.”</p>
<p>“And Natalie stopped at her house and said that she was just starving and hasn’t had any food and she said that she waited til Mom fell asleep and she snuck out of the house to get some food because she didn’t have anything. And this mom was very – this is not the first time that she has done this.”</p>	<p>“Natalie told this women (sic) that she was hungry and mom did not have any food.”</p>
<p>[In response to whether Natalie looked malnourished] “Yes, she does, she looks very thin.”</p>	<p>“Natalie is thin.”</p>
<p>[In reference to the attendance caseworker being told that Natalie said “My sister’s hungry.”] “The only other sister is XXXX, that’s the home schooled one.”</p>	<p><i>This statement was not documented.</i></p>
<p>(After Natalie left the woman’s house, the attendance caseworker said the woman said she drove away and saw Natalie) “come out of another lady’s house with more food.... My understanding is the mom who told me gave her food, and she saw Natalie leave another house with more food.</p>	<p><i>This statement was not documented.</i></p>
<p>“Our school resource officer has been involved with the family before. It was like Natalie did not come home and she was listed as a missing person slash runaway, and it was a follow-up from that.”</p>	<p><i>This statement was not documented.</i></p>

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We later asked the intake worker who handled this call, about the steps she would take to ensure the accuracy of her intake reports:

Ombudsman: Did you go back and listen to the audio before you finalized your intake report?

Intake worker: No.

Ombudsman: Okay. And would that be because you just typically don't or you didn't see a need in this case?

Intake worker: I never do. We never do, none of my co-workers.

Ombudsman: And why is that, that you never do that?

Intake worker: We don't have the opportunity to do that.

Ombudsman: From a time perspective?

Intake worker: Yes.

Ombudsman: Okay. Is that something that you wish you could in some cases have the time to actually go back and listen to even just parts of an audio call so that you make sure that you capture a complete record?

Intake worker: I think it could be beneficial.

We later asked Noard, who made the decision to reject the intake, about the information shared by the reporter during the May 27 intake. Noard told us that had he known about the statements which were not documented or not documented accurately, "I believe it would have changed my mind to an accept."

Noard told us that had he known about the statements which were not documented or not documented accurately, "I believe it would have changed my mind to an accept."

We also played segments from the intake audio recordings for Social Work Administrator Jason Geyer, who oversees CSIU.¹¹⁷ This included the intake reports from November 18, 2015, and May 27, 2016, in which both reporters described Natalie as "starving" and "very thin." Neither statement was fully or precisely documented and both intake reports were rejected. The following exchange ensued during our interview of Geyer:

Ombudsman: What's your overall reaction to listening to that and seeing important information that didn't get in?

Geyer: Well, I mean, that makes a difference. When you don't document something that needs to be documented it can make the difference between accepting or rejecting a report.

...

¹¹⁷ For the remainder of this report, we will refer to Geyer as "intake unit administrator" or "unit administrator."

Ombudsman: Does it shock you, though, that there were not one, but two reporters who both described Natalie Finn as starving and very thin?

Geyer: Yes.

Ombudsman: Those statements were not documented.

Geyer: Yep.

Ombudsman: Their intakes were rejected.

Geyer: The fact that it was not documented, that's important information to know. I suppose yes, it is surprising that it wasn't in there, yeah.

Ombudsman: How do you think that would have happened? I mean, where would that come from? What would be the – You know, earlier we talked about identifying a problem, but then trying to figure out what caused the problem. What would have caused that?

Geyer: Well, that's a good question. I don't – I don't know what caused it. I think – I mean, I don't know without getting into the workers' heads of why they missed it. I mean, I don't know. I mean, I don't know a factor to have played into it that they didn't document it. I mean, there's definitely no guidance to say don't document anything. So I guess I don't know why they missed it.

Collaterals

One aspect of completely and accurately documenting callers' statements includes seeking the identity and contact information of other sources who are knowledgeable about the child's circumstances, referred to as "collaterals" in DHS policy.¹¹⁸ Collaterals are simply other people referenced by the reporter who have relevant information about the allegation and/or the situation.

"Definitely if there's someone who told the reporter all this information, we need to know who that person is," intake unit administrator Geyer told us. "If there's a doctor who knows something that goes on, we need to know that person. We need to document that in the intake. And if it's accepted, that's there for the worker to have to be able to do their assessment."

Among the five intakes received from November 2015 through May 2016, four of the reporters provided information they had received from other people. However, none of the four intake workers asked those reporters for the identities and contact information of those collateral witnesses.

During the November 2015 intake call, the school principal told the intake worker:

[Natalie] has not shared these things directly with me. She's shared them with her case worker, her counselor and a special education assistant that she likes to talk to. And from the mother that came in and expressed concerns to me. The mother did not feel comfortable reporting it herself, but she wanted to report it to

¹¹⁸ DHS's Employees' Manual, Title 17, Chapter A(4), Topic 1, page 5.

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somebody so somebody would do something about it. So I don't have a lot of first-hand knowledge....

The intake worker did not ask the principal for those four individuals' identities or contact information. She indirectly documented the principal references by writing, "Natalie is sharing the information with other staff members in the school and from the mother."

We also reviewed the recording of the phone call that the Student Services Coordinator made in April 2016. That call contained the following exchange:

Intake worker: Anything else?

Student Services Coordinator: Anything else that I could tell you would be through third parties, and I know that that's not good. She's talked about not getting enough food, not being fed in the house before.

Intake worker: Does she get like, meals at school or –

Student Services Coordinator: She does, she gets a lot of food when she's here at school.

The intake report captured that exchange as, "Natalie has talked about not being given enough food when she is home. She is provided food when she is at school." The intake worker did not ask the reporter to identify the third parties he referenced. When we interviewed the intake worker, she acknowledged "it would have been a good idea" to ask the reporter to identify those third parties and provide their contact information.

The most problematic example regarding documenting collateral witnesses involved the May 27 report made by the attendance caseworker at Walnut Creek Campus, who conveyed information she received from a parent of another student. This included first-hand information the parent had experienced with Natalie sneaking out of the house, asking her for food, and apparently going to other neighbors for food.

As discussed earlier, the parent – later identified as the neighbor who befriended Natalie – allegedly told the reporter she did not want to call DHS because she did not want Natalie's mother to be mad at her. DHS's policy expectation to request collateral witnesses' identity and contact information does not make an exception for witnesses who reportedly do not want to contact DHS.

The intake worker had no feasible way to verify whether the reporter's statement was accurate. During our interview of the intake worker, she could not explain why she had failed to request the collateral witness's name:

Ombudsman: I did not hear you ask [the reporter] anything about that other woman, and I'm wondering why you wouldn't have done that.

Intake worker: I don't know why I didn't do that. I should have tried to get her name and phone number to see if she would talk or would be comfortable calling us.

The last intake in this section came from a West Des Moines police officer on May 31 and was based primarily on the statements of two collateral witnesses. While this report was appropriately accepted for an assessment, we found that the after-hours field worker did not obtain the collateral witnesses' names or contact information. One of those collateral witnesses happened to be the same neighbor referenced in the attendance caseworker's report four days earlier.

We do not have an audio recording of the May 31 call, but the field worker told us she did not recall asking the officer to identify the neighbor:

Ombudsman: Do you think it would have been best practice to try to get the name of that neighbor and maybe contact information?

Field worker: Yeah, that's something I definitely could have done. Usually that's included in the police report that a worker would gain and consider that a collateral that they could call. It's helpful to get that and write that in the report.

We asked a former intake worker about her practice of gathering collateral witness information. She told us it was not uncommon to receive a child abuse intake call in which the reporter's allegation was actually coming from someone else. However, this did not mean information on that collateral witness was regularly gathered:

Ombudsman: In those situations would you ever ask the reporter, "Who is this other person? Who is this teacher? What is their name?"

Intake worker: Sometimes I would and sometimes I didn't, and sometimes I would ask for their name and their phone number. Kind of the issue on that is I mean I could put that in the body of the report, but I wouldn't be able to call the person, so that's why I would generally ask them to call in to me so I could get the information, especially if I knew we were kind of at a point where we weren't going to be able to accept, because then I would never be able to get that information from that person.

...

Ombudsman: So what does the (DHS's Employees') Manual say about that situation, about, you know, you have a reporter who's giving an allegation based on information from a third party? What does the Manual say the intake worker ought to do in that circumstance?

Intake worker: I honestly don't remember.

She did not recall ever being asked by a supervisor or management to get more information about a collateral. Referring to the need for intake workers to identify collateral witnesses, unit administrator Geyer told us, "That's not been practiced on a consistent basis."

We found that a CSIU guidance document, *INTAKE: Structured Interview*, contains a section titled "Collateral," but the text does not actually address the subject. It only discusses non-custodial parents or intakes in which there is more than one reporter. We brought this issue up during our interview of Geyer:

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Ombudsman: Am I overlooking something? Is there any place in this Structured Interview document that actually tells the intake worker you need to be finding out names and contact information on these other sources when they're brought up?

...

Geyer: I didn't – I don't see – You would you think that's where it would be, is in that collateral section.

Ombudsman: And here's where I'm gonna try and tie it together. I've been wondering, could that maybe explain why, at least in the Finn intakes, the intake workers didn't do real well on collaterals?

Geyer: Yeah.

Ombudsman: Is there maybe an oversight?

Geyer: Yeah. I mean, I think it's an expectation, so it needs to be in here.

We also found that the failure to track collaterals was identified as a problem in two separate systemic reviews conducted by DHS staff. In 2006, DHS officials conducted a review of both the intake and assessment sides of the agency's child welfare program. The summary document from that review identified intake-side failures to gather and document critical information, including the identity of collateral witnesses, but it did not elaborate.

In 2017, DHS conducted a similar systemic review.¹¹⁹ The 2017 systemic review found that adequate information on collaterals was not collected in 23 of 109 intakes (21 percent) handled by intake workers at CSIU.¹²⁰ Among after-hours intakes that were reviewed, adequate information on collaterals was not collected in 3 of 33 intakes (9 percent) handled by on-call field workers.¹²¹

DHS officials conducted yet another systemic review in 2019. Although it found improvement with regard to gathering information about collaterals, it must be noted that the 2019 review involved much smaller sample sizes than the 2017 review. Reviewers in 2019 found that adequate information on collaterals was not collected in 1 of 28 (3.6 percent) **accepted** intakes handled by intake workers at CSIU; 0 of 10 after-hours **accepted** intakes handled by on-call field workers; and 0 of 14 **rejected** intakes handled by intake workers at CSIU.

When we re-interviewed intake unit administrator Geyer in May 2019, he told us, "We definitely made an effort to focus on getting collateral information" after identifying this as a problem previously and also after the Ombudsman raised the issue of collaterals during interviews of CSIU employees and managers in 2018.

¹¹⁹ This review is not to be confused with DHS's internal investigation resulting directly from Natalie's death.

¹²⁰ DHS, *2017 Intake and Assessment Case Review April to December 2017*.

¹²¹ *Id.*

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.¹²² 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.¹²³

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.”¹²⁴ Intake workers are then expected to summarize any relevant prior history in the intake report.

In response to a 2017 inquiry from a legislator following Natalie’s death, then-DHS Director Charles Palmer wrote, “Intake staff are to review the history of all assessments and intakes, rejected and accepted, when completing an intake.”¹²⁵ During our investigation, 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); and the Employees’ Manual also does not explicitly direct intake workers to summarize any relevant prior history in the intake report.¹²⁶

Former DHS Administrator Wendy Rickman 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.”

Over a six-month period beginning in November 2015, DHS received five child abuse reports about Natalie. The one common concern was that Natalie was not getting enough food at home.

Over a six-month period beginning in November 2015, DHS received five child abuse reports about Natalie. The one common concern was that Natalie was not getting enough food at home. Unfortunately, that commonality was not discovered until the fifth and final report in the series.

We found that the intake worker who handled the second intake in this series, was not aware DHS had received a

similar report about Natalie less than three months before. The first two child abuse reports had significant points in common. We found that eight concerns expressed by the school nurse were repeats of concerns expressed by the principal. Both reporters expressed concerns about Natalie not getting enough food at home, wearing the same clothes daily and not routinely bathing, her shoes falling apart, Natalie’s mental-health issues and her mother’s apparent mental-health issues, and the large number of animals in the home.

¹²² DHS’s Employees’ Manual, Title 17, Chapter A(1), page 6.

¹²³ DHS’s Employees’ Manual, Title 17, Chapter A(3), page 9.

¹²⁴ DHS’s Employees’ Manual, Title 17, Chapter A(1), page 21.

¹²⁵ From then-DHS Director Charles Palmer’s March 28, 2017, letter of response to a written inquiry from then-Senator Matt McCoy.

¹²⁶ June 4, 2019, letter of response by Deputy DHS Director Mikki Stier. 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.

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We found that the intake workers who handled the third and fourth intakes were also unaware that there were prior similar reports about Natalie. The third report in the series involved two concerns in common with the first two reports: Natalie was not getting enough food at home, and the large number of animals in the home.

By the fourth intake on May 27, DHS intake workers had received and documented in some capacity four references to Natalie not receiving enough food at home. During the fourth intake call, the attendance caseworker shared her understanding that DHS had received prior reports with the same type of concerns she was reporting. “And I believe there’s probably other reports by other community members and maybe even through law enforcement,” the attendance caseworker told the intake worker. However, no intake worker had reviewed the prior intakes and connected all the dots by this fourth call.¹²⁷

... reviewing the prior child-abuse history was not a widespread practice at that time, despite the policy directive.

We asked the intake workers and supervisors why they had not identified these repeat concerns. Their responses revealed that reviewing the prior child-abuse history was not a widespread practice at that time, despite the policy directive.

They provided a couple of reasons for that, including the fact that the expectation was not emphasized as a required practice. Our interview with one intake worker included the following exchange:

Ombudsman: What’s your belief or what’s your understanding of Department policy and what you’ve been trained on, in terms of: Should there have been any documentation in your report about any relevant information that you may have found from the previously rejected intakes?

Intake worker: I don’t think we were doing that at the time.

One former intake worker said that at the time of the Finn intakes, intake workers were not being advised by supervisors or Social Worker 4s to look at past child-abuse history. “We were just advised to look at what the current allegation was and go with that information,” one intake worker told us.

“We were just advised to look at what the current allegation was and go with that information.”

Another former intake worker, told us, “The decision to accept or reject was mostly based on what you heard in the phone call.”¹²⁸

SWS Allison told us that when he was a Social Worker 3 in the field, it was not a practice to review and document the relevant prior child-abuse history. As far back as 2006, “I never was told to document and to ensure that I had reviewed all of the previous information.” Our interview with Allison included this exchange:

¹²⁷ According to DHS’s Executive Summary, page 5, SWS Noard “was coached and counseled for not asking questions of the worker and not ensuring the history was reviewed and considered.”

¹²⁸ This same former intake worker handled a child abuse report involving the Finn family on October 5, 2016. That intake will be discussed later in this report.

Ombudsman: Let’s just go back to the period of the Finn case, 2015-2016. Why do you suppose most intake workers were not doing that kind of documentation of the prior history? Was there any particular reason why they weren’t doing that, aside from not being told to do it?

Allison: Not that I’m aware of. I don’t know why it wasn’t emphasized that that needed to be.

Not all CSIU employees shared this view. SW4 Oberbroeckling told us that it had always been an expectation to review all history, including both accepted and rejected intakes. She said that was what she did as an intake worker and it was how they trained new intake workers. Our interview with Oberbroeckling included this exchange:

Ombudsman: You’re saying in your experience – and you did work as an intake worker – you always went through the prior history and documented it in some way, and that’s the standard you go by when you are reviewing calls. Am I hearing that correct?

Oberbroeckling: Correct.

Intake workers also told us that they simply did not have time to consistently review the prior child-abuse history.

Intake workers also told us that they simply did not have time to consistently review the prior child-abuse history. We were told workers generally get 15 minutes between calls before they are placed back into ready status, meaning they are

ready to take another phone call. That is the opportunity for workers to process the new intake and/or previous intakes, including reviews of prior child-abuse history, before they are expected to take another call.

At the time of the Finn intakes, we found that intake workers could use their case management system (otherwise known as JARVIS) to display a list of all prior intakes and assessments with minimal effort. Due to the system’s limitations, however, looking up any substantive information on those prior intakes needed to be done one at a time and was a time-consuming process.

“It was extremely cumbersome to go through 10 different cases,” one former intake worker explained, “because you don’t know what they are, and then I can’t stay in my intake and be in JARVIS.” She described checking the prior child abuse history during an intake as “impossible.”

The May 31 intake report was the fifth involving the Finn family since November 2015, and it was the only one not handled by a CSIU intake worker. The same intake report was also the only one of the five to include the prior child abuse history, particularly the pattern of Natalie reportedly not getting enough food at home. “When I consulted the other intakes and looked at them, I was like why has nobody put this together?” the after-hours field worker told us. “Why has nobody realized this?”

“... why has nobody put this together?” the after-hours field worker told us. “Why has nobody realized this?”

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When we asked her how much time she spent processing the after-hours intake from Officer Granzow, she estimated it was between an hour and a half and two hours. “It was probably a little bit of a lighter night,” she said, later adding, “It wouldn’t have been a crazy, hectic, 14-call night.”

She said that doing lookups for after-hours intakes typically took longer than it would for intake workers at CSIU because on-call workers “only have one (computer) screen. You don’t have the multi screens like they do at intake. You just have one little laptop screen, so I can’t like click back and forth.” Even with that caveat, we believe she still had significantly more time to review the prior intakes – and write a summary – than is typically afforded to intake workers at CSIU. The after-hours field worker explained:

I’m invested in the evening in getting the information that’s needed versus somebody at intake, they take the intake and it’s gone and move to the next one. And they might have a timeframe of what time they’ve got to get it done by, because there’s calls on hold and waiting and a certain amount of time they have to get lookups done, take the next call, and things like that. I don’t.

Lori Lipscomb, Service Area Manager, made a similar observation about how the after-hours field worker handled this intake. “She’s after-hours,” Lipscomb told us. “She’s not on the phone all day long every day. She had one person on the phone, nothing waiting.”

The after-hours field worker acknowledged that she did not always have enough time to include a summary of the prior intakes when she was assigned to after-hours intake duties. When asked how she might have summarized the pattern in this intake report had it been a busy night, she said she would have written, “The worker assigned needs to look at the rejected intakes. They are very concerning.”

DHS officials addressed this concern after their internal review of the Finn case. “Intake supervisors are now focusing more on cases where the intake worker is making a preliminary decision to reject a report,” DHS’s internal investigation stated. “Supervisors are doing a more in-depth review of case history.”¹²⁹

According to a separate DHS document that further describes changes implemented as a result of the internal investigation, “Intake staff will consistently review accept/reject history and corresponding themes to inform intake decisions.”¹³⁰

¹²⁹ DHS’s Executive Summary, page 11.

¹³⁰ DHS, *Agency Improvements or Changes Pending Post Director Review of Finn*, (2017) page 2.

Five Child Abuse Reports: November 2015 – May 2016

DHS’s internal investigation stated, “To free up time for the additional review of proposed reject decisions, supervisors are verbally staffing all rejected intakes with intake workers and are only verbally staffing a sample of the accepted intakes.”¹³¹ We believe this change – particularly the new expectation for supervisors to review the prior history for intakes with a preliminary decision of reject – is the most significant of DHS’s intake-related improvements since Natalie’s death.

We believe this change – particularly the new expectation for supervisors to review the prior history for intakes with a preliminary decision of reject – is the most significant of DHS’s intake-related improvements since Natalie’s death.

Service Area Manager Lipscomb explained:

We put the emphasis with the supervisor to say, “Okay. You don’t have to verbally staff accept decisions anymore. Workers can go ahead and make accept decisions without bringing those to you for a decision; but you, as a supervisor, are responsible, then, for making sure that we’ve looked at history on rejects.”

“There’s been a good change where we don’t have to call every time to the supervisor,” an intake worker told us. “If we are accepting, we don’t have to call on accepts, only rejects, which gives us a breath of fresh air of having more time.”

Not everyone agreed that this was a positive change. One former intake worker told us, “Ninety nine percent of the time you need that second head to kind of review what have you got here, is this something we really need to look into or not look into.”

Following their internal review, DHS officials also addressed the concern that CSIU’s case management system was cumbersome and difficult to work with. DHS’s internal investigation stated that CSIU’s information technology system would be modified to “ease and enhance our ability to look-up history” by:

- Making pertinent information on perpetrators, all family members, previous allegations, and previous assessment findings more readily available to intake staff.
- Auto-populating look-ups from the income maintenance information technology systems.
- Exploring the use of a more enhanced, user-friendly version of Iowa Courts Online.¹³²

Referring to the enhanced ability to look-up the prior child-abuse history, SWS Allison explained that the JARVIS system now automatically auto-fills prior history into the intake document with a click of a button: “Everything is auto-generated, except for criminal history, now.”

¹³¹ DHS’s Executive Summary, page 11.

¹³² DHS’s Executive Summary, page 12.

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SW4 Oberbroeckling told us that the prior history displayed by JARVIS now includes “the allegation of abuse that was being alleged and if it was founded, confirmed, or not confirmed, so that way at a quick glance you can kind of already see, hey, we’ve got history of these kinds of allegations.”

A former intake worker described this change as “phenomenally helpful.”

Decisions to reject intakes

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.”¹³³ 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 and
- 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.¹³⁴

A. November 18, 2015, intake

DHS officials determined that the decision to reject the November 18, 2015, intake was appropriate. We disagree. Although the principal had little direct knowledge of the allegations, we believe she provided sufficient physical and behavioral indicators to warrant accepting the intake for a family assessment. Specifically, the principal said:

- Natalie’s shoes were falling apart.
- Natalie was “very thin” and “seems like she’s starving” at school. The principal also said that Natalie was hoarding food in the home and “always” told another school employee that she did not eat dinner because she got in trouble.
- Natalie had an attachment-disorder diagnosis and the principal believed Natalie’s mother had mental-health issues.

¹³³ DHS’s Executive Summary, page 4. DHS’s Employees’ Manual, Title 17, Chapter A(1), page 9, also 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. When we asked intake unit administrator Jason Geyer what those policy provisions mean, he acknowledged they are “confusing” and said they need to be rewritten.

¹³⁴ DHS’s Employees’ Manual, Title 17, Chapter A(4), Topic 8, page 1.

- There were about 30 animals in the home and the principal questioned whether that explained why Natalie appeared unkempt at school.
- A principal at another school was planning to make a child abuse report about one of Natalie's siblings.

We believe all of this information clearly established sufficient basis for accepting this intake. This finding is also supported by the following statement from DHS's internal investigation:

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.¹³⁵

For the allegation that Natalie's shoes were falling apart, the DHS's Employees' Manual states, "Failure to provide adequate clothing could be indicated by the child lacking adequate protection against prevailing weather elements, such as ... footwear that is too small or too large."¹³⁶ We believe that shoes allegedly falling apart would arguably be no less significant than shoes that are too small or too large.

It is worth noting that if this intake had been accepted, school was in session at that time; and so presumably the field worker assigned to the case could have used confidential access to speak to the children at school, away from their mother.¹³⁷ Also had this intake been accepted, the field worker may have also been able to speak to the children at their father's residence, as they were still going there on a regular basis at the time of this intake.

B. February 5, 2016, intake

DHS officials determined that the February 5, 2016, intake should have been accepted. We concur. We believe there was more than sufficient basis to have accepted this intake for a family assessment based on the statements of the school nurse.

The intake report indicated that one factor in the decision to reject was the reporter's statement that there was food in the home. Our interview of the intake worker included the following exchange:

Ombudsman: Wasn't the nurse actually saying the girl was not getting food?
Wasn't that the whole essence of what she was trying to report?

¹³⁵ DHS's Executive Summary, page 2.

¹³⁶ DHS's Employees' Manual, Title 17, Chapter A(3), page 15.

¹³⁷ Iowa Code section 232.68(3) defines confidential access as "access to a child, during an assessment of an alleged act of child abuse, who is alleged to be the victim of the child abuse." In addition, Iowa Code section 232.71B(7), which is titled "Facility or school visit," states, "The assessment may include a visit to a facility providing care to the child named in the report or to any public or private school subject to the authority of the department of education where the child named in the report is located. The administrator of a facility, or a public or private school shall cooperate with the child protection worker by providing confidential access to the child named in the report for the purpose of interviewing the child, and shall allow the child protection worker confidential access to other children for the purpose of conducting interviews in order to obtain relevant information."

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Intake worker: She didn't know for sure. I don't believe she knew for sure if the girl was getting food or not because I think at one point they asked Natalie about food, and she said there was plenty of food in the home. There was no information that there wasn't any food in the home or that she wasn't allowed to eat any food. That's what we know, is that there was food in the home and that she could get food if she asked for it, and Natalie didn't make any statements that food was being withheld from her or that she didn't have any access to food.

We believe this reasoning is flawed. The presence of "plenty of food" in the home should not have negated the reporter's statement that Natalie had lost 11 pounds in two months and appeared gaunt and malnourished. Concerns of this nature from a school nurse should have been given significant consideration.

According to the intake report, another key reason for the decision to reject this intake was that Natalie was choosing not to ask for food at home. The intake report stated in part:

No information mom is withholding food. There is food in the home. Natalie is 16 years old and knows she can ask for food, but chooses not to.

The decision to reject a report that a 16-year-old with purported mental-health issues was choosing not to eat – but only at home – resulting in substantive weight loss according to a trained medical professional contradicted DHS's prime directive for intake: "[S]afety is the paramount focus of the intake process...."¹³⁸

We believe if a school nurse reports that a child appears to be malnourished, and the nurse provides a credible basis for their determination, the underlying causes *should not matter* for the accept-or-reject decision. In this case, we believe the only question should have been whether to identify the allegation as denial of critical care for failure to provide adequate food or failure to provide necessary mental-health care.

"Knowing that we had a medical professional say that a child appeared malnourished, I mean that should cause someone to think a little differently about that situation versus a neighbor saying, 'I think she's malnourished.'"

Service Area Manager Lipscomb told us, "Knowing that we had a medical professional say that a child appeared malnourished, I mean that should cause someone to think a little differently about that situation versus a neighbor saying, 'I think she's malnourished.'"

As with the November 18, 2015, intake, it is again worth noting that if this intake had been accepted,

school was in session at that time, and so the field worker could have interviewed the children at school or at their father's residence, away from Nicole.

When we interviewed SWS Allison, we discussed what was – and was not – documented in the intake report. He explained the challenge of making the accept-or-reject decision when relying on an intake worker's account (even a particularly good one):

¹³⁸ DHS's Employees' Manual, Title 17, Chapter A(3), page 1.

Allison: There's definitely a barrier with staffing an intake versus hearing it live if you're the intake worker that's taking it. If I would have taken this intake by myself, if I took this call, I would have said accept, but I'm getting the information secondhand.

Ombudsman: Oh, I see. You mean for the supervisor who gets the verbal consult, who doesn't hear it, really has to rely on the intake worker –

Allison: Right.

Ombudsman: – and relies on their ability to capture as much as they could. Again, no human is going to get a hundred percent, but you try to get as close as you can.

Allison: Absolutely. We all make errors.

Ombudsman: I think we're both in agreement – and you tell me if we're not – that even though [the intake worker] did a great job, it just goes to show that in fact she did miss a few things. It doesn't mean she did a bad job, but it just means that she's human. Would you agree with that?

Allison: Yes.

It is unclear what led Allison to state he would have accepted this intake had he taken the call.

C. April 19, 2016, intake

We found the April 19, 2016, intake was properly rejected. The SSC provided no information suggesting Natalie sustained a physical injury from being slapped by her mother.¹³⁹ We also agree with DHS officials' determination that the allegation of failure to provide adequate supervision was appropriately rejected.

D. May 27, 2016, intake

We agree with DHS officials' determination that the May 27, 2016, intake should have been accepted. This report was made by a school attendance caseworker who said that a neighbor reported that Natalie told her she was hungry and her Mom did not have any food. The reporter also said Natalie hoarded food, was "very thin," and looked malnourished.

Significantly, a lot of critical information submitted by the reporter was not contained in the intake report. In addition, the intake worker failed to review the prior child abuse history, specifically, the previous three intakes. Had she done so, she would have found that this was the fourth child abuse report from school officials about Natalie in a six-month period, and the one common concern was that Natalie was not getting enough food at home.

¹³⁹ Iowa Code section 232.68(2)(a)(1) defines "physical abuse" as any nonaccidental physical injury, or injury which is at variance with the history given of it, suffered by a child as the result of the acts or omissions of a person responsible for the care of the child. DHS's administrative rules (441 IAC 175.21) define "nonaccidental physical injury" as an injury which was the natural and probable result of a caretaker's actions which the caretaker could have reasonably foreseen, or which a reasonable person could have foreseen in similar circumstances, or which resulted from an act administered for the specific purpose of causing an injury.

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When we interviewed the intake worker about this intake, she said, “Looking back, I wish to God I would have accepted it.” She later added, “I feel so bad in this case, and I’ll have to live with this the rest of my life, and out of it I pray that I’m a better worker for it, and I think I am.”

Allegations of inadequate food

Two former intake workers told us that at the time of the Finn child abuse reports, inadequate food allegations were typically rejected if the child was getting food at school. They said that a child allegedly not receiving food at home usually was not enough for supervisors to accept the intake. One of them stated, “Administration would look at it as, ‘If they’re getting fed at school, great. We’re done.’” SWS Allison told us: “We definitely did not accept as many food allegations back then as we do now,”

The same two former intake workers also said this practice ended abruptly sometime after the Finn case. With no explanation, they said, supervisors began accepting food-related intakes which were similar to intakes that had previously been rejected. Intake workers found this out indirectly when supervisors suddenly started “flipping” rejected intakes into accepted intakes. One of them told us, “You would see them being accepted, where before they might have been rejected, but there really wasn’t a directive from above that it was going to happen.”

CONCLUSIONS AND RECOMMENDATIONS

We found that relevant and substantial information from concerned individuals was left out of several intake reports. This is information that, according to two intake unit supervisors, impacted decisions to accept or reject reports (February 5, 2016, and May 27, 2016). We identified two intake calls only five months apart (November 18, 2015, and May 27, 2016) where both reporters described Natalie as “starving” and “very thin.” Neither intake report included those descriptions and both were rejected. We believe both intake workers should have documented these statements and asked the reporters to elaborate, but neither did so.

We conducted an online review of the policies and procedures for centralized intake units in several other states. Through this review we discovered that for all child abuse intakes received by telephone at Tennessee’s centralized intake unit, intake workers are required to read their written narrative of the reporter’s statements back to the caller before the conclusion of the call.

In response to a July 2, 2019, email inquiry from our office, Heather Ray, Director of the Office of Child Safety for Tennessee’s Department of Children’s Services, explained:

Reading back the narrative at the end of the call is our way of being Customer Focused. With us reading back the narrative, we are verifying to the caller that their concerns were heard and documented. We also use this as a way to ensure we have captured all of the necessary details. This gives our staff the ability to proof read their narratives as they read it back, but also can catch any gaps in information which then will prompt them to ask additional questions.

Without such a policy, child abuse reporters in Iowa have no way of knowing whether the key parts of their reports are documented accurately. Had such a policy been in effect at Iowa’s CSIU in 2015-2016, we believe it may have allowed reporters in the Finn case to point out

significant errors and omissions, and may have resulted in several intakes being accepted instead of being rejected.

In addition, we found that intake workers were not consistently collecting information about collateral witnesses. They also were not consistently reviewing the prior child abuse history for the subjects of these reports. Based on our interviews, it appears that both of these were ongoing oversights at that time. The only intake in which the prior history was reviewed and the dots connected was handled by an on-call field worker who had some extra time. This supports our position that slowing the process a bit creates opportunities for increased quality.

DHS's internal investigation also stated, "Intake staff needed retraining on acceptance criteria – ruling a case in rather than ruling it out. If an intake decision is borderline or questionable, the allegation should be accepted for assessment."¹⁴⁰ According to a separate DHS document, "If we have multiple contacts regarding a family, accept if borderline."¹⁴¹

The Ombudsman recommends that DHS:

- 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 the alleged abuse.**
- 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.**
- 4. Continue monitoring rates by which intake workers collect information on collaterals and continue stressing the importance of collecting that information.**
- 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.**
- 6. Continue to monitor and solicit feedback from intake workers for any concerns about conducting system checks.**
- 7. Update its Employees' Manual to explicitly require intake workers to review all prior intakes and assessments, not just rejected intakes.**

¹⁴⁰ DHS's Executive Summary, page 11.

¹⁴¹ DHS, *Agency Improvements or Changes Pending Post Director Review of Finn*, (2017), page 1.

Assessment opened on May 31, 2016

DHS'S ASSESSMENT PROCESS

The preamble to DHS's child-welfare administrative rules states: "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)." ¹⁴²

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

There are two types of assessments: a child abuse assessment and a family assessment. ¹⁴³ The family assessment is for "less serious allegations of child neglect." ¹⁴⁴ It is only used in "denial of critical care" cases where the child is not in imminent danger. ¹⁴⁵ 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. ¹⁴⁶ 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. ¹⁴⁷ 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. ¹⁴⁸ A field worker must begin a child abuse assessment within 24 hours of receiving the report.

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. ¹⁴⁹ A family assessment does not include a determination of whether abuse occurred. ¹⁵⁰

All assessments are required by law to address child safety, family functioning, culturally competent practice, and family strengths and needs. ¹⁵¹ The primary purpose of any assessment is

¹⁴² IOWA ADMIN. CODE r. 441—175 (Division II, Preamble).

¹⁴³ IOWA CODE § 232.68(5).

¹⁴⁴ 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.

¹⁴⁵ See "Iowa Child Welfare Assessments by Disposition, County and Year" at <https://data.iowa.gov/Public-Safety/Iowa-Child-Welfare-Assessments-by-Disposition-County-and-Year>.

¹⁴⁶ *Id.*

¹⁴⁷ IOWA CODE § 232.71B(1)(a)(1).

¹⁴⁸ *Id.*

¹⁴⁹ IOWA CODE § 232.68(5)(b).

¹⁵⁰ IOWA CODE § 232.68(5)(c).

¹⁵¹ IOWA CODE § 232.68(5)(a).

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.¹⁵² 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.¹⁵³ 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.¹⁵⁴

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.¹⁵⁵ 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 determine whether they witnessed the alleged abuse.¹⁵⁶ All assessments must include a safety assessment¹⁵⁷ and a risk assessment,¹⁵⁸ as well as an evaluation of the home environment.¹⁵⁹

Field workers are trained to observe the child's environment to determine whether it poses a safety risk and whether it has any relevant information regarding the allegation (i.e., evidence of drug use, adequacy of food).¹⁶⁰ 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.¹⁶¹

Field workers are also instructed to interview anyone who is familiar with the child and family and who can provide additional information.¹⁶² These collateral witnesses may include:

- People identified by the family or by the field worker.
- Neighbors.
- Teachers and daycare staff.
- Medical professionals and other service providers.

¹⁵² IOWA CODE § 232.71B(1)(b).

¹⁵³ DHS's Employees' Manual, Title 17, Chapter B(3), page 3.

¹⁵⁴ IOWA ADMIN. CODE r. 441—175.25(5)(a)(2).

¹⁵⁵ IOWA CODE § 232.71B(6).

¹⁵⁶ 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."

¹⁵⁷ A safety assessment identifies and addresses imminent threats to a child's safety, according to DHS's November 2, 2017, letter of response.

¹⁵⁸ DHS's November 2, 2017, letter of response 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."

¹⁵⁹ IOWA CODE § 232.71B(4)(a)(2).

¹⁶⁰ DHS, *How-Do-I? Guide CPS Assessment*, page 5.

¹⁶¹ IOWA CODE § 232.71B(6).

¹⁶² DHS's Employees' Manual, Title 17, Chapter B(1), page 32a.

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- Law enforcement officers.¹⁶³

Effective selection and interviewing of collateral witnesses is critical to accurate and timely decision-making.¹⁶⁴

Although child abuse assessments must be completed within 20 business days, field workers can continue working cases beyond that timeframe, but only under certain specified circumstances. This is referred to as an “addendum” – defined in part as “a thing added.”

Under DHS’s administrative rules, an assessment can be placed on addendum under the following circumstances:

1. New information becomes available that would alter the finding, conclusion, or recommendation of the report.
2. Substantive information that supports the finding becomes available.
3. A subject who was not previously interviewed requests an interview to address the allegations of the report.
4. A review or a final appeal decision modifies the report.¹⁶⁵

An addendum must be completed within 20 business days.¹⁶⁶

FAMILY ASSESSMENT (JUNE 1 – JUNE 14)

In response to the May 31 accepted intake, the assessment was assigned to field worker Amy Sacco as a family assessment. The family assessment designation meant that Sacco had to see the Finn children within 72 hours¹⁶⁷ and complete her assessment within 10 business days of the report.¹⁶⁸

Sacco’s assessment report shows she reviewed the May 31 intake and the four rejected intakes involving the Finn family from the prior six months on **June 1**. She also left a voicemail requesting a return call from the children’s mother, Nicole, and made an unannounced visit to the Finn residence. Sacco’s report stated in part:

(N)o one answered the door, and a card was left in the door. CPW Sacco heard several dogs barking inside the home. CPW Sacco observed all the windows in the front of the home to be covered with what appeared to be brown paper or black plastic. CPW Sacco also observed a black Honda Pilot parked in the driveway.

¹⁶³ DHS’s Employees’ Manual, Title 17, Chapter B(1), page 32a.

¹⁶⁴ DHS, *How-Do-I? Guide CPS Assessment*, page 5.

¹⁶⁵ IOWA ADMIN. CODE r. 441—175.26(1)(a)(8).

¹⁶⁶ *Id.*

¹⁶⁷ IOWA ADMIN. CODE r. 441—175.25(1)(b).

¹⁶⁸ IOWA CODE § 232.71B(13)(a)(2).

That same day, a West Des Moines police officer was dispatched in response to a request from staff at Walnut Creek Campus. The officer was present when school staff tried to conduct a welfare check of the Finn children at the family's residence, but nobody answered the door.

The next day, **June 2**, Sacco's assessment report stated that she called Walnut Creek Campus at 9 a.m. and was told that school was out for the summer. Later, during an interview with DHS officials, Sacco could not recall whether she asked to speak with the school officials who were the reporters for the four prior rejected intakes. According to school officials, the last day of school that year was Thursday, June 2.¹⁶⁹

According to Sacco's assessment report, she then called Officer Granzow, the reporter for the May 31 intake, and left a message requesting a return call. Sacco's report indicates she did not receive a return call from Officer Granzow and she made no more attempts to contact him. Officer Granzow told us that he did not recall receiving a message from Sacco.

Several days passed before Sacco made her second unannounced visit to the Finn residence on **June 7**. When no one answered, she again left a business card on the door. On this same day, DHS mailed separate form letters to Nicole and Joe Finn, notifying them of the recently opened family assessment. The letters, titled "Child Abuse and Family Assessment Parental Notification," identified all four children residing at that time with Nicole and explained the assessment process. The letters also identified the specific allegation that was the subject of the assessment:

Denial of critical care (also known as neglect) – lack of food, shelter, clothing, medical or mental health treatment, supervision or other care necessary for a child's well-being when these expose a child to danger or significant harm.

On Friday, **June 10**, Sacco documented that she received a voicemail from Detective Kraig Kincaid, who was assigned to investigate the case opened by Officer Granzow. Detective Kincaid told us he was the School Resource Officer at Walnut Creek Campus during the 2015-2016 school year. Detective Kincaid said that one of the first things he does when he gets assigned to a child-welfare case is to contact DHS to see which worker is handling the case. "[A] lot of times it makes it much easier where the two departments, us and DHS, can work together and do the interviews and the investigation ... I've just found that if we're both there at the same time, it's much easier to get the investigation completed."

Sacco wrote in her assessment report that Detective Kincaid mentioned "report 16-2613" in his voicemail. Sacco told us that she assumed – correctly as it turns out – that "report 16-2613" was a reference to the incident report authored by the reporter, Officer Granzow.

Sacco made her third unannounced visit to the Finn residence on **June 13**. According to her report, Sacco observed a black Honda Pilot in the driveway, as she had during her first visit, but nobody answered so she left another business card in the door. She documented that she later spoke by phone with Detective Kincaid, who told her that police had received concerns from

¹⁶⁹ It is worth noting that when the attendance caseworker made her May 27 child abuse report, she told the intake worker that May 17 was the last day Natalie Finn had attended Walnut Creek Campus.

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different sources about the Finn children not having enough food and appearing underfed, being locked in their rooms, and constantly being dirty.

Detective Kincaid also told Sacco that he had been to the Finn home several times, but no one answered despite a black Honda Pilot that was owned by Nicole being in the driveway. He too had observed the front windows of the home were covered by paper or dark plastic. Detective Kincaid said that Nicole was being investigated for allegedly breeding and selling animals without a license. According to Sacco's report, Detective Kincaid said animal control had been to the home several times and no one ever answered the door, but dogs could be heard barking inside the home. Detective Kincaid stated he had "many concerns regarding the children and would like to work jointly with DHS to assure the safety of the children."

Detective Kincaid told us that during the same phone conversation, he asked Sacco if she needed a copy of Officer Granzow's May 31 incident report. Detective Kincaid said Sacco replied that she had the information that she needed. He added, "I believe I asked her if she had it, because I read that last paragraph in the [Officer's Granzow's police incident] report saying that [DHS] didn't receive it."¹⁷⁰

Also on June 13, Sacco addressed a letter to Nicole at her supervisor's direction:

My name is Amy Sacco with Polk County DHS. I have received a Family Assessment referral regarding concerns reported to DHS. I would like to meet with you and your children, at your earliest convenience. At this time this referral is just a Family Assessment, which means there can be no child abuse findings.

If you fail to meet with me, I will have no other choice but to reassign this case from a Family Assessment to a Child Abuse Assessment, which could possibly result in the allegation (sic) that have been reported, being founded or confirmed for the alleged abuse that was reported. Also, a Child Abuse Assessment could potentially result in the Polk County Attorney having to become involved.

I can be reached at my office [phone number] or on my cell phone [phone number].

Sacco's supervisor, Beth Avery, later told DHS officials that she asked Sacco to send the letter "to try and compel this mom to work with us."¹⁷¹

CONVERSION TO CHILD ABUSE ASSESSMENT AND VACATION

Avery told DHS officials that she and Sacco discussed the Finn case on **June 13** and agreed to reassign it from a family assessment to a child abuse assessment.¹⁷² In her report, Sacco wrote

¹⁷⁰ At the end of his May 31, 2016, incident report, Officer Granzow noted that he was unable to fax his May 31 incident report to DHS.

¹⁷¹ Transcript of DHS's interview of Avery, November 7, 2016, page 16.

¹⁷² *Id.* at page 3.

that this action was taken “since the safety of the children hadn’t been assured.”¹⁷³ Had the case remained a family assessment, Sacco’s deadline for completing her report would have been the next day, June 14. After converting it to a child abuse assessment, the due date for completion became June 28.

June 14 marked the last day Sacco was in the office before her vacation that would last until June 24. She sent Avery an email that stated:

This is the [family assessment] I told you about yesterday, and it does need reassigned [from a family assessment to child abuse assessment]. I have made several attempts to make contact with the family. I am working with [law enforcement] now regarding this case as they have been unable to make contact with the family.

This is the family that is selling animals including chickens from the home without a breeders license now animal control is having a hard time making contact with the family to check out the conditions of the home and the amount of animals they have.

I will talk to you about this case later when I get back to the office after my CPC because I have a weird feeling about this case, because there are other concerns that the mother is locking her children in their rooms, and when I have been out to the home all the windows of the rooms are covered with garbage bags or brown paper.

Avery in turn sent an email to her supervisor and other DHS officials, explaining that the case had been reassigned from a family assessment to a child abuse assessment. Her email largely mirrored Sacco’s email to her.¹⁷⁴

Also on the afternoon of June 14, after two weeks of unsuccessful attempts to contact Nicole, Sacco received an email from Nicole that read:

Hi, Amy. I had a card in my door last night from you. I also had a card from you that the boys found in the front yard last week. (I thought it belonged to an adopter who came here for my rescue).

¹⁷³ This reassignment was authorized by administrative rule 441—175.25(3)(b), which states in part, “A family assessment requires the cooperation of the family; should a family choose not to participate, the department is required to transfer the assessment to the child abuse assessment pathway for a disposition.”

¹⁷⁴ Avery’s email read:

“Pathways reassigned. Children unsafe. CPW has made several attempts to make contact with the family and is now working with LE [law enforcement] now regarding this case and they have been unable to make contact with the family. This is the family that is selling animals including chickens from the home without a breeders license now animal control is having a hard time making contact with the family to check out the conditions of the home and the amount of animals they have. Additionally, there are other concerns that the mother is locking her children in their rooms, and when CPW has been out to the home all the windows of the rooms are covered with garbage bags or brown paper.”

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I accidentally updated my iPhone this morning and it is stuck in that. I have been waiting all morning to call you. I can only imagine what this is about. Natalie has been having some major issues with her reactive attachment disorder and she always goes into hoarding or survival mode at the end of the school year. This year was especially different because she had more freedom, because she is 16

now, she was at a school where she could leave the property at lunch, and she was walking to and from school.

If my phone unfreezes soon, I will give you a call. If not, I will have to wait for the fully-charged battery to die and call you tomorrow. I don't want you to think that I am ignoring you now that I know that your card was meant for me last week.

I will talk to you soon. Again, I am sorry I didn't know you were wanting to contact me.

Niki Finn

Although she read Nicole's email that same day, Sacco told us that she did not respond because she was busy with an unrelated child abuse assessment.

CASE ACTIVITY FROM JUNE 24 – AUGUST 16

When Sacco returned from her vacation on Friday, **June 24**, she noted in her assessment report that Nicole had left a voicemail on her office number at 8 p.m. on June 16. Sacco then called Nicole and left a message requesting a return call; this was her second attempt to reach Nicole by phone.

When Sacco spoke to Detective Kincaid that day, he told her that he had made two more unsuccessful attempts to contact Nicole at her residence. Sacco noted in her report that Detective Kincaid said he would be free after the following Tuesday to interview Nicole and the children with Sacco.

Avery approved Sacco's request to put the case on addendum. Avery later told DHS officials that she did this because the due date for completing the assessment was just a few days away (June 28) and Sacco had still not been able to determine whether the children were safe.

Sacco completed the initial and subsequent safety assessments on June 24, her first day back from vacation, concluding that the Finn children were safe even though she still had not seen them.

Sacco completed the initial and subsequent safety assessments on June 24, her first day back from vacation, concluding that the Finn children were safe even though she still had not seen them. Sacco made the following entry in her initial safety assessment:

The mother Nicole has avoided CPW Sacco and it is believed that Nicole has been home when CPW Sacco has been to the home. Nicole has only made contact with CPW Sacco via email and has left a message on CPW Sacco's office

number after hours when CPW Sacco wouldn't likely be in the office. CPW Sacco has also provided Nicole CPW Sacco's cell phone number on the business cards left at the home but Nicole hasn't tried to contact CPW Sacco on the cell phone.

Sacco completed the risk assessment and determined that the family scored a moderate risk.

Detective Kincaid filed an incident report that same day, stating in part:

We have had history with this family in the past. Detective Weatherall was working a missing person case in regards to Natalie who returned home.¹⁷⁵ The schools have called and made referrals to DHS regarding this family. We have attempted to make contact with the family at the residence and nobody will ever answer the door...

After speaking with Amy Sacco from DHS, she stated that the case was in family assessment and will soon be transitioned into a child abuse investigation.¹⁷⁶ Per our conversation, she (was) advised on the history we have had with the family. Sacco stated once the case turns into an investigation, she was going to work with the Polk County Attorney's Office to see what we can get done in order to get inside the home. Once arrangements and a possible resolution to our issue is confirmed, Sacco was going to contact me with the findings for further investigation. Since our conversation, I have been to the residence two additional times. The same vehicle is in the drive, all windows are closed and covered.

After documenting on June 24 that she suspected Nicole was avoiding her, Sacco made only one attempt to contact Nicole over the next 32 days.

After documenting on June 24 that she suspected Nicole was avoiding her, Sacco made only one attempt to contact Nicole over the next 32 days. This attempt was her fourth unannounced visit to the Finn residence on **July 5**. As with Sacco's prior visits, a black Honda Pilot was parked in the driveway, but nobody answered so she left another business card in the door.

No further substantive action occurred until **July 19**, when Sacco and Avery discussed the case. Although the deadline for completing the addendum was eight days away (July 27), they agreed that Sacco would miss the deadline because Avery would be on vacation from July 21 through August 5. Avery advised Sacco to continue her efforts to contact Nicole. When we interviewed Sacco, she said Avery told her that if those efforts were not successful, Sacco should arrange to send a "county attorney letter" to Nicole, asking her to attend a "county attorney meeting" on August 8, when Avery would be back in the office.¹⁷⁷

¹⁷⁵ This was a reference to the incident reported in the April 19, 2016, child abuse report.

¹⁷⁶ This transition occurred 10 days earlier, on June 14.

¹⁷⁷ During her testimony in Nicole Finn's criminal trial, Sacco said the purpose of a "county attorney letter" and "county attorney meeting" is for child abuse assessments where a family is resistant, and the child's safety has not been assured, to encourage the parent(s) "to talk about the allegations and to emphasize we need to see the children, we need to assure safety and we need to see the home."

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Sacco later told us that as field worker, she had “a couple” of prior assessments that involved the use of a county attorney letter and a county attorney meeting.

According to Sacco’s report, Detective Kincaid called her on **July 22** and reported that he had visited the Finn residence several more times to no avail. He told Sacco that the black Honda Pilot was parked in the driveway each time, leading him to believe Nicole was home.

Sacco emailed Nicole on **July 26** asking for a phone call. Sacco’s email, her first email of any kind to Nicole, said she would contact the Polk County Attorney’s Office if she did not hear from Nicole by the end of the day on July 28.

On **July 27**, Detective Kincaid filed an incident report which stated in part:

Since the issuance of this case and contacting Amy Sacco of DHS, both she and I have made weekly visits to the residence in attempts to make contact with Nikki. Each time has led to nobody answering the door. Amy has attempted contact by phone but Nikki will only call back after hours and leave a message.

Detective Kincaid’s report also described his observations from his two most recent visits to the Finn residence:

The same vehicle is in the drive, all windows are closed and covered. On July 26th, the front window shades were slightly open. I could see inside and observed what looked to be 7 dogs inside kennels in the main living area. Again when I knocked on the door, nobody answered and the dogs barked.

After being contacted by Sacco, Assistant County Attorney Jim Ward addressed an **August 2** letter to Nicole, asking her to attend a meeting scheduled for August 8:

The Polk County Department of Human Services (DHS) began an investigation after it was alleged that your child/children were put at risk. DHS has approached our office with concerns about the safety and welfare of your children. DHS is requesting that our office intervene based on the information learned during the investigation.

I would like to give you the opportunity to discuss this matter with me before a final decision is made about how to appropriately handle this matter.

If you would like to take advantage of this opportunity, you need to attend a meeting at the **Department of Human Services, located at River Place, 2309 Euclid Ave., Des Moines, Iowa**. The meeting should take approximately twenty minutes. (Emphasis in original.)

Date & time of meeting: **Monday, August 8, 2016 at 9:00 AM** (Emphasis in original.)

The value of this meeting is that you will have the opportunity to meet with me and a Supervisor with the Department of Human Services to discuss the situation

and determine if there is a way to resolve this matter in a way that addresses the safety concerns for your child/children and to provide support for your family. You are not required to attend this meeting, but this will be your last opportunity to address us before a final decision is made on what if any additional action will be taken.

Nicole did not show up for the **August 8** meeting with Sacco, Avery, and Assistant County Attorney Jesse Ramirez. Sacco and Avery then asked Ramirez to pursue the matter through the juvenile court process that authorizes DHS to enter a home and interview or observe a child when permission has been refused by a parent.

Ramirez filed a “Motion to Compel Interview of a Child Pursuant to Iowa Code section 232.71B(5)” the next day.¹⁷⁸ The motion described the procedural history of the case, including the allegations raised in the May 31 intake report, the three prior rejected intakes in 2016, and DHS’s unsuccessful attempts to ensure the children’s safety. The motion concluded, “Given the allegations and non-compliance by the mother, the State believes there is sufficient evidence of probable cause to support the Court ordering DHS to interview and observe the children in order to assess their safety and well-being.”¹⁷⁹

A juvenile court judge issued an “Order to Compel Interview of a Child Pursuant to Code section 232.71B(5)” the same day, stating in part:

The Court, being fully advised in the premises and based on said motion, FINDS, that probable cause does exist to grant the motion to compel the interview of the above named children filed by the State. IT IS THEREFORE THE ORDER OF THE COURT THAT the above named children shall be interviewed by DHS.¹⁸⁰

Sacco told us that this was her first experience with an Order to Compel.

Sacco received the court order and emailed a copy to Nicole on **August 10**. “Attached is a Motion to Compel which is a court order that grants DHS the right to interview your children and to enter your home,” Sacco’s email stated. Sacco assessment report stated that her email “requested Nicole contact CPW Sacco to schedule a time to meet.” However, Sacco’s August 10 email to Nicole did not include any such request.

Sacco documented that she received a delivery-and-read receipt, indicating Nicole had opened Sacco’s email. She then called Detective Kincaid to schedule a time for them to meet at the Finn residence to serve the court order. “Det. Kincaid stated that he was in training for the rest of today,” Sacco wrote in her report, “but would meet CPW Sacco tomorrow at 2 pm at the family home to serve the order and see the children.”

¹⁷⁸ Although the authority to compel an interview of a child is in Iowa Code section 232.71B(6), the Motion to Compel cited a different Code section, 232.71B(5), which states, “Child abuse determination. Unless otherwise prohibited under section 234.40 or 280.21, the use of corporal punishment by the person responsible for the care of a child which does not result in a physical injury to the child shall not be considered child abuse.”

¹⁷⁹ A copy of the Motion to Compel is attached as Appendix A.

¹⁸⁰ A copy of the court order is attached as Appendix B. The Order included a handwritten note, apparently initialed by the judge, which stated, “And DHS is authorized to enter the home to interview or observe the children.”

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Sacco met Detective Kincaid at the Finn residence at 2 p.m. on **August 11** to attempt to serve the Order to Compel. This was Sacco's fifth unannounced visit to the home. According to Sacco's report:

Det. Kincaid knocked on the doors and the windows in attempts to get someone to answer the door. Through the front window CPW Sacco observed one of the male children standing in the living room of the home and when the child noticed that he could be seen through the front window he immediately left the area.

Sacco called Nicole and left a message asking her to come to the door. When Nicole did not do so, Sacco and Detective Kincaid left the property.

In his August 11 incident report, Detective Kincaid wrote in relevant part:

When knocking on the door, all the dogs inside the residence were barking loudly. Upon looking into the window while she was knocking, I was able to see one of the kids bringing a dog inside from the back yard. The child looked to be XXXX Finn and am sure [he] could hear the door being knocked on. We knocked for about 5 minutes and nobody would come to the door. Amy then called Natalie (sic) while we were standing on the front porch and she did not answer. Amy left her a voicemail.

All other windows to the residence are covered. I was able to see inside the main front window and did notice what looked to be seven dogs inside the residence and 2 cats. The living room furniture was littered with blankets and clothing. I could see what appeared to be either dog or cat food on a bowl, sitting on the coffee table. There was a small path leading through the living room to the kitchen. This path was made with dog kennels and large litter style boxes. **Amy advised that she was going to speak with the county attorney again to see what else can be done to interview the kids and check the residence to continue our investigation.** (Emphasis added.)

Amy and I have checked the residence every week since the issuance of this case. A copy of the order to compel was left inside the door.

According to Sacco's report, she received a phone call from Nicole at 8:45 p.m. that evening. Nicole said she was sick with lupus and fibromyalgia and that was why she had not answered the door earlier in the day. Sacco tried to set up a time the next day to meet, but Nicole said she was not feeling well and they would have to meet the next week. She also said that she was a single mother with several debilitating diseases and did not feel safe answering the door to just anyone. Sacco documented that she again tried to set up a time the next day to meet, but Nicole became argumentative. Sacco ended the call by saying that she would contact Nicole in the morning to schedule a time to meet.

On Friday, **August 12**, Sacco called Nicole (her fourth such attempt) and left a message requesting a return call. Sacco had told Detective Kincaid the day before that she would recontact the county attorney's office for guidance regarding her inability to see the Finn

children despite having the Order to Compel. There is no indication that Sacco did so until August 16.

The following Monday, **August 15**, Sacco called Nicole (her fifth such attempt) and again left a message requesting a return call. Sacco left yet another message for Nicole on Tuesday,

August 16, and then recontacted the county attorney's office. Sacco later told DHS officials that she was told to treat the Order to Compel as a search warrant.¹⁸¹ She called Detective Kincaid that afternoon and they agreed to meet at the Finn residence the next day at 1:30 p.m. to execute the Order to Compel.

Later that same afternoon, Nicole emailed Sacco's supervisor, Avery. The email, which had a subject line stating "Illness," read:

Hi. I left you a message on Friday regarding a case with Amy Sacco that I wanted to discuss with you. I wanted to let you know that I am ill and suffering from symptoms of my Fibromyalgia and Lupus and am not feeling well. I don't want to be accused of avoiding anyone regarding this incident again. I will be in touch soon.

Thank you. I hope you understand.

Nicole Finn

Avery responded that she tried to call Nicole back but got no answer, and that she would be happy to speak with her. Avery further wrote:

You need to understand that it is important that you cooperate with our assessment. Because you have not allowed us access to your children or your home, a court order has been issued by a judge that requires that DHS observes and interview your children; and that DHS to observe your home. If you are interested, as you say you are, in not being accused of avoiding anyone regarding this incident then I highly recommend that you allow Amy Sacco to enter your home and interview your children.

If you have any questions or want to talk with me about this situation, I would be happy to do so. Please call me at [phone number]. If I do not answer please be sure to leave a message about the best time to reach you.

AUGUST 17 VISIT TO THE FINN FAMILY RESIDENCE

Detective Kincaid spoke with Assistant County Attorneys Ward and Ramirez on **August 17** about the court order.¹⁸² They told him to make every reasonable effort to get someone to

¹⁸¹ Transcript of DHS's interview of Sacco, November 1, 2016, page 12.

¹⁸² Detective Kincaid's incident report dated August 18, 2016.

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answer the door, but if no one answered then forced entry was granted.¹⁸³ Detective Kincaid then contacted Sacco and advised they would meet at the residence at 1:30 that afternoon.

According to Sacco's assessment report, she arrived at the Finn residence at the scheduled time. This was her sixth and final visit to the Finn residence. Detective Kincaid arrived accompanied by two officers and another detective.¹⁸⁴ Detective Kincaid's incident report read:

I knocked on the door very loudly, as the doorbell did not function, and announced that it was the police department. I knocked numerous times and continued to advise that it was the police department and they needed to open the door to speak with us.

Sacco wrote that four police officers knocked on all doors and windows "and when the door was not answered Det. Kincaid stated if the door was not opened the door was going to be breached." Sacco later told DHS that the four police officers "were yelling, screaming, knocking on windows ... you know, knocking on doors, said that if Nicole didn't open the door they would breach the door. They had the battering ram ready to go."¹⁸⁵

Detective Kincaid's incident report stated:

After about 5 minutes, Officer Anderson and I attempted to get into the back yard to check the back door and Nicole answered. Nicole was resistant in allow (sic) us to enter the home and had to be explained numerous times that the court order signed by the judge granted us access to the residence and interviews with the children. She remained in the door and argued and finally I just walked past her into the residence.

Sacco followed behind and found all four children inside the home. Since the May 31 child abuse report from Officer Granzow, **78 days** had elapsed before Sacco made contact with the Finn children.

Since the May 31 child abuse report from Officer Granzow, **78 days** had elapsed before Sacco made contact with the Finn children.

Sacco told us that their plan was for herself and Detective Kincaid to first go through the house to look at any safety concerns while the other police officers met with Nicole and the children. After that, she and Detective Kincaid would interview the children individually and then meet with Nicole. According to her assessment report, Sacco's purpose for searching the residence was to see if there was any evidence supporting the allegation that the children were not getting enough food at home, or that Natalie was being locked in a room.

Sacco told us:

I went through every nook and cranny of that home. Detective Kincaid and I did. I went in the basement. I got into closets to see if kids could have been locked in,

¹⁸³ *Id.*

¹⁸⁴ *Id.*

¹⁸⁵ Transcript of DHS's interview of Sacco, November 1, 2016, page 18.

if there were devices, like locking devices, in doors jamming them in or any way that they were being locked inside closets or bedrooms. There was carpet on the floor. There was bedding and bedroom sets in the kids' bedrooms.... I opened the cabinets. I opened the refrigerator. There was food.

Nicole and the children sat in the living room while Sacco and Detective Kincaid walked through and observed the home. Sacco wrote that the home was very dirty and cluttered, with several dogs in crates and several cats in the home. The children's bedrooms were cluttered with piles of clothes on the floor. Sacco wrote that she found no locks or mechanisms on the bedroom doors that could have been used to lock the children in their rooms. She stated, "It was observed that each of the children had their own bed and adequate clothing."

Detective Kincaid described similar information in his report:

Inside the house I located approximately nine dogs, 12 cats, three rabbits, one of which was running loose in the basement. The residence smelled of animal odor and litter box odor. The complaint reported to us was that the children did not have food and were also locked inside their rooms from the outside. Amy and I checked every door and did not find any evidence of locks on the outside of the bedroom doors.¹⁸⁶

Sacco and Detective Kincaid then observed the kitchen and found the family appeared to have an adequate supply of food. Sacco's report stated:

The cupboards and the pantry were full of soup, pudding, jello, spaghetti, several jars of spaghetti sauce, crackers, chips, bread, cookies, cereal and boxes of hamburger helper. The refrigerator was stocked with bottle water, sports drink, lunch meat, condiments and milk. The freezer contained a variety of different frozen meat.

Detective Kincaid described the same sequence of events in his report:

We also checked the refrigerator and cabinets for food. There was plenty of food in all locations and what appeared to be a roast in a crock pot cooking. Other than the animals and smell, the house was pretty organized and the children had access to all food and bathrooms.

Sacco told our office that when she initially tried to engage the children, Nicole would interrupt, telling Sacco that she was not going to interview her children alone. Sacco's report stated that Detective Kincaid was able to get Nicole to meet with him outside. But when we interviewed Detective Kincaid, he told us that he had no recollection of persuading Nicole to meet with him outside, or of him leaving the living room with Nicole while Sacco was trying to interview the children.

¹⁸⁶ Detective Kincaid told us, "We didn't see anything that would resemble a lock or an alarm, or anything like that." During court testimony, one of the Finn children testified that just as Sacco and the police arrived, another child took the "beeping" alarm that had been attached to the door of the bedroom and put it in the hamper.

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According to Sacco, she tried to get Natalie to leave the room with her, but Natalie refused.¹⁸⁷ Sacco continued trying to engage the children in conversation but each child said they were not going to talk. Natalie told Sacco to “fuck off” and said she and her siblings were safe. “Natalie stated that she wasn’t going to say anything because she didn’t want to be taken away from her mother,” Sacco’s report stated.

Soon after, however, Sacco began receiving some substantive responses from Natalie:

CPW Sacco asked Natalie why she was seen pan handling for money and going to neighbors’ homes asking for food. Natalie stated that she is addicted to junk food and her mother doesn’t allow Natalie to eat junk food. Natalie stated that she was pan handling to buy junk food and was asking the neighbors to specifically give her junk food. Natalie stated that last school year she stole \$60 from another student to buy junk food.

Detective Kincaid wrote in his incident report, “All the children stated they have always had enough food to eat and most choices were on their own will, not by their mother.”

Sacco told us that she was unable to conduct a thorough interview of the children under the circumstances. She estimated her interview of the children lasted 10 or 15 minutes.¹⁸⁸

Sacco then interviewed Nicole, who described Natalie’s mental-health diagnoses, prescription medications, and medical providers. According to Sacco’s report, Nicole was not able to state the last time the children had seen their pediatrician, but asserted they would be seen for physicals before school started. Nicole told Sacco that Natalie would be going into 11th grade at Walnut Creek Campus. She then discussed her safety concerns with Natalie reportedly panhandling for money at a gas station:

Nicole stated that Natalie does a lot of thing (sic) for attention and to get people to feel sorry for her. Nicole reported that she can’t supervise Natalie 24 hours a day. CPW Sacco asked what services she currently has or has tried with Natalie. Nicole stated that Natalie has only had therapy and is prescribed medication for her mental health.

CPW Sacco attempted to provide Nicole with information on BHIS¹⁸⁹ and post adoption services through Kidsnet,¹⁹⁰ but Nicole was not interested in the information. Nicole reported that last school year she started an application with

¹⁸⁷ Transcript of DHS’s interview of Sacco, November 1, 2016, page 21.

¹⁸⁸ Transcript of DHS’s interview of Sacco, November 1, 2016, page 22.

¹⁸⁹ Behavioral Health Intervention Services. According to an online document created by Children and Families of Iowa, BHIS are voluntary services that offer tools and support to families so they can create a supportive environment at home. Link: <http://cfiowa.org/programs/mental-health/behavioral-health-intervention-services/>.

¹⁹⁰ According to the Iowa Kidsnet page on LinkedIn, “Iowa KidsNet is a statewide collaboration of agencies that utilizes a unique, cohesive approach to provide recruitment, training, licensing and continued support to individuals who wish to become foster and adoptive parents. For more information, call 1-800-243-0756 or visit www.iowakidsnet.com.” Link: <https://www.linkedin.com/company/iowa-kidsnet>.

the school counselor to get Natalie into the PMIC¹⁹¹ program at Orchard Place, but the application was not finished. CPW Sacco encouraged Nicole to contact Orchard Place and start the application process for PMIC directly with Orchard Place. Nicole stated that she thought that she needed a referral. CPW Sacco explained to Nicole since Natalie is on title 19¹⁹² Natalie wouldn't need a referral. Nicole stated that she and Natalie needed to talk about what would be best for Natalie. CPW Sacco discussed with Nicole the importance of getting Natalie's mental health under control especially since Natalie will be 18 in less than two years.

Sacco wrote that Nicole said she was diagnosed with lupus and fibromyalgia and accused Sacco of creating stress that had caused Nicole's pain to flare. Because the pain caused her to spend most of the day in bed, Nicole said she depended on the children to help tend to the animals in the home through Nicole's pet rescue. Nicole also claimed that the children had been scared that DHS was going to take them away from her.

In her report, Sacco also wrote that the three children "appeared to be thin, unkempt, and had a very flat affect but didn't have any visible signs of being undernourished." Sacco observed that a fourth child "appeared to be physically fit and well groomed." Sacco later described her impression of the children's physical appearances in an interview with DHS officials:

All three of them were ... I mean, I'm not a doctor but they were thin; thin children, they were small children. But I didn't notice like any ... sunken eyes or, you know, gauntness.¹⁹³

Detective Kincaid, who had previously seen some of the children at school, told us that he did not observe anything unusual with their appearance that day:

Detective Kincaid: They looked normal, like every time I've seen them at school.... [One child] in particular, looked just like when I had talked to [the child] at school. I mean there wasn't any remarkable difference....

Ombudsman: So if anybody were to assert that, well, those children had to be malnourished at that August 17th home visit, that was not what you were seeing?

Detective Kincaid: Based on my prior experience in seeing the kids, no, they didn't look any different to me.... I told [Sacco] they looked like they always do to me.

During the August 17 home visit, Sacco also asked about the children's hygiene. Natalie and a sibling said they did not shower and they wore the same clothes for several days at a time because it got them attention at school. Another sibling refused to discuss hygiene habits while a

¹⁹¹ Psychiatric Medical Institute for Children. According to an online document created by the Iowa Department of Inspections and Appeals, PMICs are institutions which provide more than 24 hours of continuous care involving long-term psychiatric services to three or more children in residence. Link: https://dia-hfd.iowa.gov/DIA_HFD/StreamPDF?cmd=showPDF&dir=entBooksDir&delete=no&doc=EntBook11.

¹⁹² Title 19 refers to Medicaid, a federal and state government health insurance program for people with low incomes. Medicaid was originally authorized by Title 19 of the Social Security Act Amendments of 1965.

¹⁹³ Transcript of DHS's interview of Sacco, November 1, 2016, page 23.

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fourth child showered daily. Nicole told Sacco that there was nothing she could do to make the children shower.

Sacco encouraged Nicole to use any and all resources to help with concerns she had about her children's behavior. Nicole stated that she did not need any help because she knew what was best for her children. Sacco told Nicole that if DHS continued to get reports about the children, there could be other assessments.

Nicole stated that she did not feel well and asked that they end the interview. Sacco and Detective Kincaid thanked Nicole and the children and left the home.¹⁹⁴

Detective Kincaid's report concluded:

Amy and I conversed at the conclusion and noted that nothing would be done in a criminal matter. The claims stated were unfounded and unfortunately the case took too long due to lack of cooperation with Nicole. Amy was going to contact medical care providers for the children and verify records. This case is considered closed.

When we asked Detective Kincaid what was on his mind when he left the Finn residence that day, he replied: "The biggest thing like when I spoke with Amy (Sacco) is, 'Did we miss anything from the report that was provided that Officer Granzow had? Was there anything that we didn't check?' I felt confident that we checked everything at that particular time that was needed."

Back at her office, Sacco discussed her findings from the home visit with Avery. They agreed that Sacco would keep the case open so she could seek the children's medical records. Sacco told us, "I just wanted something to show a trend in weight." Avery told DHS officials why she agreed with the idea of seeking the children's medical records: "Just wanting to make sure that if the kids are thin that they really are ... that's really their natural state; that they're thin children. Not that they have necessarily been losing weight."¹⁹⁵

Sacco told us that she then called Assistant County Attorney Ramirez to report her findings from the home visit and the results of her consultation with Avery. She said Ramirez advised her that there was insufficient basis to initiate a Child in Need of Assistance (CINA) proceeding or to request removal of the children.¹⁹⁶ Sacco described her conversation with Ramirez to our office:

I said, "What about maybe another motion maybe to get the kids seen [by a doctor] just so that we can." He said, "You had nothing when you went in for the first motion. You're not going to get a second motion." ... I knew Nicole wasn't going to take them to be seen if I requested.

¹⁹⁴ During her court testimony, Sacco estimated they were inside the Finn residence for about 35 minutes. Detective Kincaid told us he thought they were there for about 45 to 50 minutes.

¹⁹⁵ Transcript of DHS's interview of Avery, November 7, 2016, page 26.

¹⁹⁶ Transcript of DHS's interview of Sacco, November 1, 2016, page 23.

Avery received an email from Nicole the next day with a subject line reading, “Re: Amy Sacco.” Nicole’s email, which was copied to Assistant County Attorney Ramirez, claimed Sacco and the police officers had entered her home illegally.

Later that afternoon, Avery forwarded Nicole’s email to Sacco, with a note stating, “Please review this email and attachment when you have a chance.” We found no indication that anyone from DHS ever responded to Nicole’s complaint.

CASE-RELATED ACTIVITY FROM AUGUST 18 – OCTOBER 24

According to her assessment report, Sacco called the children’s pediatrician on **August 18** and requested medical records for all the Finn children. “They were going to fax” the records, Sacco said during her first interview with DHS officials.¹⁹⁷ Sacco made additional calls to the doctor’s office on **September 12** and **October 17**. Those three phone calls constituted the only action Sacco took on the addendum over a 67-day period. By **October 24**, the day a 9-1-1 call was made from the Finn residence, the addendum was 90 days overdue.

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ANALYSIS

We found a number of serious missteps with how the May 31 assessment was handled by Sacco and Avery. Key witnesses were never identified or interviewed, the case was plagued by procedural irregularities, and the case was allowed to languish for extensive periods of time.

Failure to identify and contact key collateral witnesses

Similar to the obligations of intake workers, field workers are advised to interview collateral witnesses who are familiar with a child and family and who can provide additional information.¹⁹⁸

Iowa Code section 232.71B(8)(a) states:

The department may request information from any person believed to have knowledge of a child abuse case. The county attorney, any law enforcement or social services agency in the state, and any mandatory reporter, whether or not the reporter made the specific child abuse report, shall cooperate and assist in the assessment upon the request of the department.

As stated earlier, effective selection and interviewing of collateral witnesses is critical to accurate and timely decision-making.¹⁹⁹

¹⁹⁷ Transcript of DHS’s interview of Sacco, November 1, 2016, page 24.

¹⁹⁸ DHS’s Employees’ Manual, Title 17, Chapter B(1), page 32a.

¹⁹⁹ DHS, *How-Do-I? Guide CPS Assessment*, page 5.

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A. Failure to identify and contact neighbor who befriended Natalie

The neighbor who befriended Natalie was an instrumental witness in the case. She was the neighbor who had submitted the second report to WDMPD on May 31, 2016, and she had personally witnessed Natalie's very concerning behavior.

Sacco documented that the first thing she did with her newly assigned assessment was to review the May 31 intake report. That intake report described a call to police from a neighbor who lived up the street and who was "concerned as Natalie (Finn) reports not having food and being locked in her room."

Even with the limited information in the intake report, Sacco should have realized the potential significance of what that neighbor might know and the need to identify that individual so Sacco could speak with her. We believe Sacco should have viewed the neighbor as a potentially crucial collateral witness who might have had more direct information about the allegations than the officer who had called DHS.

Although the intake report did not identify that neighbor, it did identify the officer who spoke with the neighbor. Presumably, all Sacco needed to do to identify the neighbor was to speak with Officer Granzow²⁰⁰ or obtain his incident report.²⁰¹ If Sacco had taken either of those steps, she would have learned the name of the neighbor who befriended Natalie.

Unfortunately, Sacco took minimal steps to obtain Officer Granzow's report. The day after Sacco was assigned to the case, she called Officer Granzow and left a message. When we asked Sacco why she called Officer Granzow, she responded, "What was documented in the intake was vague compared to maybe what information he had."

Sacco did not receive a return call from Officer Granzow and she made no more attempts to reach him. Sacco told us that she did not know why she did not continue trying to reach Officer Granzow.

Detective Kincaid said Sacco told him that "she had the information that she needed" and so he did not send Officer Granzow's incident report to her. Sacco told us that she did not recall this exchange but acknowledged that she did not ask Detective Kincaid for the report because she assumed it had no additional relevant information. Had she obtained the incident report, Sacco would have learned that the neighbor reported seeing large blisters on Natalie's feet, and that Natalie had asked the neighbor for gauze to wrap her blisters. This alleged physical injury was

²⁰⁰ When dealing with a newly assigned assessment, field workers are advised to contact the reporter if the information from the intake report is unclear or incomplete, according to DHS's Employees' Manual, Title 17, Chapter B(3), page 4. That would have applied here, since the intake report did not identify the neighbor who had been in contact with Natalie.

²⁰¹ Social Work Administrator Tracy White, who led DHS's internal investigation of the assessment assigned to Sacco, told us it would have been "best practice" for Sacco to have obtained Officer Granzow's police report about the matter.

not included in the May 31 intake report as we found that Officer Granzow did not share this information with the after-hours field worker.²⁰²

During our interview of Sacco, we showed her a copy of Officer Granzow's incident report (16-2613), which Sacco had not seen previously:

Ombudsman: [I]f you had been privy to that information back at the time ... would any of that have had any impact on what you did with the assessment?

Sacco: I mean it still jumps out at me. The lack of food, that's the main concern that I'm still seeing through all of this. But I mean we have [the neighbor who befriended Natalie]–

[The neighbor who befriended Natalie] is the neighbor who made the report to law enforcement. She could have been contacted.

Ombudsman: Do the blisters in any way enter your radar from the CPW angle?

Sacco: I guess to a point, but like so she said she has no shoes, but then she has shoes, and she's seen wearing flip-flops and she's seen wearing shoes. I would have to know more about the blisters and what they looked like.

Ombudsman: How would you done that?

Sacco: Well, I would have asked the person who saw it.

We interviewed the neighbor who befriended Natalie and found she had even more information than was contained in the police report. The information she provided was concerning. The neighbor told us in response to our question about what led her to observe the blisters:

We interviewed the neighbor who befriended Natalie and found she had even more information than was contained in the police report.

Neighbor: She was limping. I said, "What's wrong, Natalie?" "Oh, I don't know." I said, "Did you do something to your leg or your foot, or something?" She sat down, and I said, "Let me see your feet."

Ombudsman: And what did you see?

Neighbor: They were like broken blisters, like blood, not scabby, but like just smeared blood on the bottom of her feet.... It seriously looked like somebody burned her feet, to me. That's what it looked like, because they were not in places where you would get a blister from walking.

²⁰² This information was in Officer Granzow's incident report, which he had wanted to fax to DHS the same day he made his child abuse report.

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If Sacco had been privy at that time to the neighbor's report that it "looked like somebody burned" Natalie's feet – and because there was no indication that the injury was accidental – it could have led to a physical abuse allegation.²⁰³

B. Failure to contact Natalie's mental health therapist

Sacco did not receive much information from Nicole about her children. Despite the relative dearth of communication between the two, Nicole informed Sacco about Natalie's mental-health issues in two different communications. The first was in Nicole's June 14 email to Sacco, in which Nicole wrote that Natalie was "having some major issues with her reactive attachment disorder (RAD)."

The second occurred during the August 17 home visit. In her assessment report, Sacco wrote that Nicole said Natalie was "diagnosed with ADHD, Depression, and Reactive Attachment Disorder" and was prescribed three medications.

According to Sacco's report from the August 17 home visit:

CPW Sacco asked what services she currently has or has tried with Natalie. Nicole stated that Natalie has only had therapy and is prescribed medication for her mental health.

Immediately after the August 17 home visit, Sacco discussed her findings with Avery. Avery said during her first interview with DHS officials that Sacco expressed concern that Natalie had a diagnosis for reactive attachment disorder but "mom was not getting her the mental health treatment. So that was something that (Sacco) definitely was interested in making sure that she got her back into."²⁰⁴

²⁰³ DHS's Employees' Manual, Title 17, Chapter A(4), Topic 5, provides the following guidance for determining whether to accept a report of alleged physical abuse for an assessment:

Topic 5: Criteria for Accepting an Allegation of Physical Abuse

For a situation to be assessed as physical abuse, there must be a reasonable belief of the following:

- A nonaccidental physical injury²⁰³ has occurred, or an injury at variance with the history given of it has occurred, and
- The injury has been suffered by a child or an injury is likely to have occurred given the information reported, and
- The child has been injured as a result of acts or omissions of the person responsible for the child's care.

... Use deductive reasoning or inference to determine if the information amounts to a report of child abuse which should be accepted. The reporter does not have to indicate specific injuries for you to reasonably infer that injuries could have resulted from the activity described and therefore, this is an allegation of physical abuse.

You must be able to determine the type of abuse being alleged even when the reporter does not use specific terminology. It may be possible to make reasonable inferences that would cause a report to become a case based upon descriptions of what occurred, so detailed and accurate information is essential.

... **Accept the report for assessment unless there is no doubt that the injury was accidental.** (Emphasis added.)

Consider:

- The reasonableness of the degree or force used in relation to the situation.
- The degree of injury to the child.
- Whether the injury was foreseeable.
- Whether attempts were made to avoid injury to the child.

²⁰⁴ Transcript of DHS's interview of Avery, November 7, 2016, page 24.

But Sacco did not act on her concerns about Natalie's mental-health issues. When we asked Sacco why she did not contact Natalie's mental-health therapist, she replied:

My issue was just verifying the weight issue of the children. That was what my issue – that's what I wanted to verify in medical records, the medical issue on the weight of the children. I don't know why I didn't contact [the mental-health therapist], but – yeah, I don't remember.

C. Failure to make contact with other witnesses

Iowa Code section 232.71B(8) contemplates that field workers will sometimes find it helpful to speak with other mandatory reporters, not just the one who made that specific child abuse report. This case was assigned to Sacco for almost five months. During that time, Sacco did not interview any of the eight mandatory reporters who had called DHS about the Finn children in 2015 and 2016.

Sacco also did not interview any neighbors or school officials – the people who had the most contact with the Finn children other than their mother. In fact, Sacco did not speak with any collateral witnesses, with the exception of Detective Kincaid. It is worth noting that Sacco attempted to contact Officer Granzow (one call) and the children's pediatrician (three calls), but she did not persist with those efforts.

During her interviews with DHS officials and our office, Sacco indicated that at least part of the reason she did not contact any of the Finns' neighbors was because she was concerned about divulging confidential information. In making these comments, it appeared Sacco was unaware that agency policy specifically states, "Once a report of child abuse becomes a case, rules around confidentiality and privileged communication are waived during the assessment process."²⁰⁵

Sacco's first interview with DHS officials included this exchange:

DHS administrator: So during the course of this open addendum, school had resumed.

Sacco: Correct.

DHS administrator: So did you attempt to contact school?

Sacco: I didn't. I was more focused on getting like some information because ... and I thought the medical records would give what I was looking for.²⁰⁶

...

DHS administrator: Do you think, and I understand you were making attempts to contact [their pediatrician] to get the medical records, but do you think that the school nurse would have been a reliable source of information?

Sacco: Yes.²⁰⁷

²⁰⁵ DHS's Employees' Manual, Title 17, Chapter B(1), page 32a.

²⁰⁶ Transcript of DHS's interview of Sacco, November 1, 2016, page 25.

²⁰⁷ *Id.* at page 28.

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DHS officials' interview with Avery revealed that she was not aware that Sacco had not contacted the neighbor referenced in the May 31 intake report. DHS officials asked Avery what direction she gave Sacco about contacting collateral witnesses:

Avery: I did not give her direction to contact neighbors.

DHS administrator: Why not?

Avery: You know I don't know, I think that obviously that would be an oversight, you know, especially if it was in the additional information that that should have ... we should have asked to find out who that neighbor was and to talk with neighbors. I agree with that.²⁰⁸

No attempt to contact children's father

Among the parties that a field worker must attempt to interview during a child abuse assessment are the subjects of the report and people who have relevant information to share regarding the allegations.²⁰⁹ The subjects of a report include the parents of an abused child.²¹⁰ Field workers are advised that interviewing the parent who is not the alleged perpetrator has several purposes: find out what that parent knows about the alleged abuse; gather information related to the risk of abuse; and determine that parent's capacity to protect the child.²¹¹

From the beginning, Sacco struggled to make contact with Nicole and her children. During that entire time, Sacco could have reached out to Joe Finn, the children's father and Nicole's ex-husband. Joe's name and address or phone number was on all of the intake reports, including the May 31 intake that led to the assessment assigned to Sacco.²¹² The Finn children were still spending weekends at their father's house through the first month of the assessment.²¹³ If Sacco had contacted Joe before her mid-June vacation, or even shortly after her return, Sacco might have been able to speak with the children at their father's residence and away from their mother.

But Sacco never contacted Joe. She later told DHS officials that she did not realize the intake reports contained Joe's contact information:

[But Sacco never contacted Joe.]

DHS administrator: Reviewing all the rejected intakes, did you know that his address and phone number were listed consistently in each one?

Sacco: I didn't, no.

DHS administrator: And that he's had the same phone number since at least February of 2015. Did you notice his contact information in those?

²⁰⁸ Transcript of DHS's interview of Avery, November 7, 2016, page 8.

²⁰⁹ IOWA ADMIN. CODE r. 441—175.25(3)(a).

²¹⁰ IOWA ADMIN. CODE r. 441—175.21.

²¹¹ DHS's Employees' Manual, Title 17, Chapter B(3), page 14.

²¹² Joe Finn would have automatically been sent a notice of the family assessment on the fifth business day after the date the intake was accepted.

²¹³ According to DHS's assessment report dated October 24, 2016, Joe Finn "indicated that he had the children with him every weekend until about the end of June or early July."

Sacco: I didn't ... I was just looking more for, you know, just what was rejected, what was the concerns.

DHS administrator: When you realized you didn't have a good number for him, and you didn't think you had a contact address for him, did you go back through the rejected intakes to see if there was information about the NCP (non-custodial parent)?

Sacco: I didn't. No ... I don't know.²¹⁴

Avery told us that Sacco "said she didn't have the address or the phone number for the dad." But Avery said that on October 25, the day Natalie died, "I picked up the report and I said, 'Well Amy, it's right here in the report.'"

Failure to reassign the case during extended leaves

The need to reassign the case to another field worker in order to meet that deadline should have been obvious to Avery.

Sacco went on vacation from June 15 to June 24. On her last day in the office, the family assessment was converted to a child abuse assessment that would need to be completed in another 10 business days, based on the 20-day deadline. Sacco's vacation accounted for seven of those days. The need to reassign the case to another field worker in order to

meet that deadline should have been obvious to Avery.

During Avery's interviews with DHS officials and our office, she acknowledged that she should have reassigned the case to another field worker in light of Sacco's absence and the fact that Sacco had still not seen the children to assure they were safe. "I think it would have been better to reassign the case given that she was going to be gone for that period of time and she hadn't made contact with the family," Avery told us.

We also found that Avery failed to reassign the case during Sacco's second extended leave (September 16 to October 13). During this time, DHS received two additional intakes about the Finn children.²¹⁵

DHS's internal investigation identified this as an issue for corrective action: "When a staff goes on leave and safety has not been assured, the case needs to be reassigned to a different worker."²¹⁶

²¹⁴ Transcript of DHS's interview of Sacco, November 1, 2016, page 25.

²¹⁵ These intakes will be discussed at length later in this report.

²¹⁶ DHS's Executive Summary, page 12.

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Failure to take timely steps

After unsuccessfully trying to contact Nicole Finn during the first two weeks of June, Sacco received an email from Nicole over the noon hour on June 14. That email was the first communication of any kind from Finn to Sacco. But Sacco did not respond to that email until July 26, a delay of 42 days. In fact, we found that Sacco did little substantive work on the case in the month following her return from vacation.

Sacco did not respond to that email until July 26, a delay of 42 days. In fact, we found that Sacco did little substantive work on the case in the month following her return from vacation.

Our interview of Sacco included this exchange about the delay:

Ombudsman: So I was wondering, under the circumstances, if the goal was to get in the home and talk to the family, why you didn't respond to that June 14 e-mail in over a 42-day period.

Sacco: I don't know. It felt like – I'm going to be honest. In the e-mail that she sent it was an e-mail to say, "I'm just kind of giving you a little information to make it look like that I'm concerned and want to meet with you." But it felt like she was blowing me off at the same time, and I felt like the e-mail, it was just her way of just kind of avoiding meeting with me, and then with the phone call, I could actually physically talk to her.

Ombudsman: Except she wasn't returning your calls.

Sacco: Yes.

Because Sacco's attempts to make contact with Nicole using other modes of communication had been unsuccessful, Sacco should have, at a minimum, made her supervisor aware of this email from Nicole before leaving on vacation. Sacco should have replied to Nicole's email immediately upon her return from vacation. Instead, she took no notable action on the case until July 5 when she attempted an unannounced visit of the Finn residence. Under the circumstances, we believe Sacco should have been using a multi-faceted approach in her attempts to contact Nicole. This should have included phone calls, unannounced visits, and emails.

Another failure to act in a timely manner relates to the county attorney letter. Avery told us she believed in retrospect that the county attorney letter should have been sent much sooner, ideally within the first 20 days of the assessment. Avery said Sacco would have been aware of the county attorney letter because it was widely used in cases where parents resisted a field worker's efforts to observe the children. "I can't imagine that she had worked there that long and wouldn't know about the county attorney letter, or have used it," Avery told us.

When we asked Sacco whether the county attorney letter should have been sent to Nicole in June, Sacco replied, "Looking back, yes, it could have been done sooner, but I was following what Beth (Avery) was instructing me to do.... The county attorney letter didn't come up until the 19th of July."

Sacco's comment about "following what Beth was instructing me to do" struck us as disingenuous and in conflict with her prior statement that "my objective was to get in the home to see the children." Sacco told us that she had used a county attorney letter in a couple of previous assessments. So even if her supervisor did not bring it up, in June Sacco was already familiar with the county attorney letter as a useful tool.

Our conclusion is further supported by Detective Kincaid's June 24 incident report, which stated that Sacco told him that "she was going to work with the Polk County Attorney's Office to see what we can get done in order to get inside the home." Although Detective Kincaid's report did not state when Sacco told him that, it occurred no later than June 24 (the date of Detective Kincaid's report).

It is worth noting that when Nicole did not attend the August 8 meeting she had been invited to, it only took one day for the county attorney's office to obtain the Order to Compel, which was the key to enabling Sacco to finally see the children.

Not only did inaction prevent milestones from being reached in the case, we believe the continuous delays had a practical effect on Sacco's ability to determine what was actually going on in the home and allowed Nicole time to coach her children and present a functioning home to DHS and law enforcement.

Not only did inaction prevent milestones from being reached in the case, we believe the continuous delays had a practical effect on Sacco's ability to determine what was actually going on in the home and allowed Nicole time to coach her children and present a functioning home to DHS and law enforcement. Court testimony from one of the children indicated that they were instructed to "go downstairs and get your mattresses, bring them up and sleeping bags and something else" because "the DHS lady" was coming. The same child testified, "We had our mattresses in our room with the bunkbed. My brother brought up futon so it was like before everything happened." They also got fresh clothes and showered.

The child's court testimony included this exchange:

Child: I was scared. My mom always told me – she told me quite a lot that if we get caught, you're going to go to jail.

Prosecutor: We get caught doing what?

Child: If we get caught with you guys, the way you look.

Prosecutor: So there you are, there is the police officers. Did that remind of you of what your mom said?

Child: Yes. So I was just scared seeing my parents get put in jail.

Prosecutor: Did you talk to either the police or the DHS lady?

Child: I really didn't want to talk at all.... My mom told me to tell them that we were eating, we were getting the supply in water, food and everything that we needed. She told us to say that, so I believed her and I said that.

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The court testimony of another child included a similar exchange:

Prosecutor: Well, when the DHS lady was there, and you knew Officer Kincaid, why didn't you tell them, hey, this is what our situation is?

Child: Because mom told us that day and the day before if we say anything to go against her, she is going to jail and she'll be mad at us.

The same child also testified that the alarm attached to the door of the bedroom they shared had been removed and placed in the hamper when DHS and police arrived:

Prosecutor: When the DHS and the police got into your house, do you remember that day, was the alarm on the door?

Child: It was supposed to be. It was in the hamper.

Prosecutor: The alarm was in the hamper?

Child: Yes.

Prosecutor: How did it get off the door?

Child: When mom was in the doorway of the house, [another child] ran to the door and took it off the door.

Sacco's lack of urgency in the case only got worse after her August 17 home visit. After deciding to keep the addendum open to seek the children's medical records, Sacco displayed no urgency over the ensuing two months. She called the doctor's office on August 18, September 12, and October 17. These were Sacco's only actions regarding the Finn addendum over a period of 67 days. As of August 18, the addendum was already 23 days beyond its due date. As of October 24, it was 90 days overdue. During her first interview with DHS officials, when asked whether she had any sense of urgency on the case after the August 17 home visit, Sacco responded:

As of August 18, the addendum was already 23 days beyond its due date. As of October 24, it was 90 days overdue.

Yes and no because, again, if I would have closed out the report that day, it would have been a not confirmed case.... And I felt like I was digging just to dig, just to find something because I felt like there was something there.²¹⁷

Avery's lack of oversight in the case deserves its own criticism. After Avery put the case on addendum on June 24, we were unable to find that she took any action regarding the case until her July 19 consultation with Sacco. The result of that consultation was limited to accepting that Sacco would not meet the July 27 deadline for completing the addendum, and that Sacco should set up a county attorney meeting with Nicole in early August, after Avery returned from vacation.

²¹⁷ Transcript of DHS's interview of Sacco, November 1, 2016, page 25.

Our interview of Avery included this exchange:

Ombudsman: Were you aware that over about a month there, Amy Sacco only made one attempt to contact Mom after determining that she believed Mom was avoiding her? Were you aware of that?

Avery: I don't believe so.... I would not be in favor of just making one attempt to get in touch with Mom during that next period.

As a veteran child-welfare employee with 19 years of experience with DHS, and 34 years of experience overall, Avery should have realized that putting the case on addendum in late June was a "last resort" to assess the safety of the children. This made Avery responsible to ensure that the case was handled in a timelier manner so as not to miss another deadline. She did not meet that responsibility.

Avery also provided no oversight on the addendum after the August 17 home visit. Avery's first interview with DHS officials included the following exchange:

DHS administrator: So Amy requested the medical records on August 18th and then didn't do anything with this case again until September 12th when she left a message for the nurse about the medical records not yet being received, which is a 25-day gap.... So at this point the case is severely overdue on addendum (47 days late). Did you seek Amy out during this time to find out what she was doing on this case?

Avery: No and I will be honest with you, not that I haven't been honest all along, but I lost track of this case. I did not realize it was still on addendum.²¹⁸

"I lost track of this case. I did not realize it was still on addendum."

Avery later added, "I should have more closely reviewed the reasoning for keeping the case open on addendum."²¹⁹

After their August 17 consultation, Avery and Sacco did not discuss this case again until October 25, just hours after Natalie was pronounced dead.

After their August 17 consultation, Avery and Sacco did not discuss this case again until October 25, just hours after Natalie was pronounced dead.

Procedural irregularities

A. Botched execution of the court order

We identified two concerns with how Sacco executed the Order to Compel. First, Sacco should *not* have sent the court order to Nicole before executing that order. Doing so expanded the opportunity for Nicole to prepare before Sacco entered the home and observed the children. During her first interview with DHS officials, Avery said that when the court order was received

²¹⁸ Transcript of DHS's interview of Avery, November 7, 2016, pages 26-27.

²¹⁹ *Id.* at page 33.

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on August 10, she recalled telling Sacco “you need to get out there on your order. You don’t wait.”²²⁰

Sacco should *not* have sent the court order to Nicole before executing that order.

In response to our inquiry on this issue, DHS officials told us, “It is best practice to do unannounced home visits on child abuse assessments, even more critically so with” an Order to Compel.

A newspaper article indicated that Sacco said she emailed the court order to Nicole at the direction of Avery and Assistant County Attorney Ramirez.²²¹ When we interviewed Avery, however, she denied giving any such directive to Sacco:

I don’t have a recollection of telling her to do that, and I don’t know why we would ... email a copy of an order. I would think that we would just serve it. We would have the police and my worker go to the home and serve it as opposed to emailing it.

Second, Sacco should not have left the Finn residence on August 11 without calling the county attorney’s office to request advice or without consulting Avery. Sacco and Detective Kincaid went to the Finn residence the day after getting the court order, hoping to speak with the children. While Detective Kincaid knocked on the doors and windows for several minutes, Sacco placed a phone call to Nicole, who they suspected was inside. But nobody came to the door. Sacco and Detective Kincaid eventually gave up and left.

Detective Kincaid wrote towards the conclusion of his August 11 incident report that “Amy (Sacco) advised that she was going to speak with the county attorney again to see what else can be done to interview the kids and check the residence to continue our investigation.” This shows that Sacco realized, while outside the Finn residence on August 11, that she needed to recontact the county attorney’s office for advice about how to execute the court order.

The months-long failure by Nicole to respond to DHS and law enforcement contacts, the presence of at least one Finn child and likelihood that others were in the home, and what should have been a growing urgency and concern over the safety of the children warranted that Sacco at least attempt to seek the county attorney office’s advice before leaving the property that day. Had she done so, she presumably would have learned that police could have used force to gain entry to the home that very day.

Sacco, however, did not recontact the county attorney’s office until five days later, on August 16. That was when she was advised that the court order should be treated like a search warrant. During her second interview with DHS officials, Sacco stated:

Sacco, however, did not recontact the county attorney’s office until five days later, on August 16.

²²⁰ Transcript of DHS’s interview of Avery, November 7, 2016, page 20.

²²¹ Lee Rood, *Fired social worker: I was a scapegoat in Natalie Finn starvation case*, Des Moines Register, January 5, 2018.

I contacted the county attorney when couldn't get (sic) to see mom, and Jim and Jesse at the County Attorney's office is like, "treat this like a search warrant; if they have to breach the door, they have to breach the door."²²²

With help from the WDMPD, Sacco finally gained access to the Finn residence on August 17. We believe her five-day-long delay in recontacting the county attorney's office may have unwittingly created yet another opportunity for Nicole to conceal what was actually going on in the Finn residence.

B. Assessing the children as safe without seeing them

According to DHS's internal investigation of Sacco,²²³ she said she always identified children as "safe" on safety assessments, even if she had not seen them, as she believed she could not identify children as "not safe" unless she had confirmed that herself.

When we interviewed Sacco, she gave us a slightly different explanation: "It's just how I had been doing it in these situations, because you had to fill out [the safety assessment] to get to the addendum, and then you go back and change it after the addendum."²²⁴

When we interviewed Avery, she said she was unsure if an assessment could be converted to an addendum unless it says the children are safe.

However, Social Work Administrator (SWA) Tracy White, who led DHS's internal investigation of the assessment assigned to Sacco, told us that Sacco and Avery were mistaken about this issue:

Ombudsman: A worker could be putting a case on addendum, but on the safety assessment mark "unsafe"?

White: Yes.

Ombudsman: You can still get to the addendum?

White: Yes.

C. Placing case on addendum contrary to rule

As noted earlier in this report, an addendum is allowed, and must be completed within 20 business days, under the following circumstances:

- New information becomes available that would alter the finding, conclusion, or recommendation of the report.
- Substantive information that supports the finding becomes available.
- A subject who was not previously interviewed requests an interview to address the allegations of the report.

²²² Transcript of DHS's interview of Sacco, November 10, 2016, page 84.

²²³ DHS's "Investigation Summary for Amy Sacco, SW3."

²²⁴ DHS letter from Mikki Stier, November 8, 2018.

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- A review or a final appeal decision modifies the report.²²⁵

When Sacco's assessment was placed on addendum, it did not meet any of these criteria. Avery acknowledged to our office that her decision to put the case on addendum was not consistent with agency policy, as Sacco clearly was not going to complete her work on the case within the timeframe of 20 working days.

When we interviewed Avery, she explained:

There would be no way that we would just close this out and stop. And say, "Well, we couldn't get in." So that's why I closed it out and said, "Nope, we've got to put this on addendum, you need to keep working on this." So I put it on addendum, which would then have it due the end of July.... You can't work the case if you don't have anything open.

SWA White agreed that putting the case on addendum "probably was their only option at that point."

Even though Avery had no other option under the circumstances to keep the case open, putting the case on addendum was contrary to rule. We agree the case needed to be kept open, but we cannot ignore the fact that this was a violation of rule.

Caseload

DHS's Child Welfare Model of Practice includes a standard that field workers' caseloads "are reasonably in accord with recommended national standards." DHS officials told us that the recommended national standard for field workers is no more than 12 new cases each month (including family assessments and child abuse assessments, as well as dependent adult abuse assessments).²²⁶

When we interviewed Avery, she acknowledged that she and Sacco made mistakes in their handling of the assessment involving the Finn family. But Avery also referred to "this unrealistic caseload" which she said hindered their ability to meet their obligations. "I believe that this situation is overwork of the worker," Avery told DHS officials. "I also believe that it's going to happen again. And so I would hate for this whole thing to happen and then have us say, well the problem was Amy Sacco and Beth Avery and not take a look at the systemic problem we have."²²⁷

When we interviewed Sacco, she said that due to her caseload, "It always felt like you were running with your head on fire." As a result, Sacco said, the Finn assessment "went on the back burner."

"There's 20 workdays in a month," Sacco told us. "You can assume you get one case a day, so you're getting 20 cases a month." DHS data regarding Sacco's caseload shows otherwise:

²²⁵ IOWA ADMIN. CODE r. 441—175.26(1)(a)(8).

²²⁶ DHS letter from Mikki Stier, November 8, 2018.

²²⁷ Transcript of DHS's interview of Avery, November 16, 2016, pages 57-58.

Table shows number of new cases assigned to Sacco in 2016 by month

Month	New Cases
January	13
February	14
March	14
April	20
May	17
June	11
July	12
August	16
September	10
Average	14.1

Sacco’s average caseload of just over 14 cases per month was above the recommended national standard, but not the dire situation portrayed by Sacco and Avery. “That is in line with what all of our other staff were at that time as well,” said Vern Armstrong, Administrator of DHS’s Field Operations Division.

SWA White told us she was surprised that Sacco’s caseload was not higher: “In my opinion, with the caseload this low, [Sacco] had plenty of time to do everything right, and she didn’t.” When we asked White about Avery’s statement that “this situation is overwork of the worker,” White responded:

I would adamantly disagree. I believe that Amy Sacco had no sense of urgency on this case ... but she definitely did on other cases, so she knew what to do and she had time to do it, in my opinion. And my opinion is that she had plenty of time to do more on Natalie Finn’s case.

We agree.

CONCLUSIONS AND RECOMMENDATIONS

Opened on the last day of May, the Finn assessment should never have hinged on a mid-August home visit. Instead, Sacco should have been in contact with the children’s father and the neighbor who had called police within the first week or two of June.

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Had Sacco made just those two contacts without delay, that could very well have led to three significant differences in how the assessment proceeded. First, Sacco may have been looking at an additional allegation of physical abuse, based on the neighbor's observations of the blisters on Natalie's feet. Second, Sacco might have been able to interview the children at their father's home or at school, away from Nicole, which may have allowed Sacco to better understand what was actually going on at Nicole's residence. And if that happened, Sacco would have been able to assess the children's safety within the first 20 days, avoiding the need to involve the county attorney's office and seek a court order.

Nobody will ever know what might have transpired if Sacco had taken just those basic steps in a timely manner.

In addition, a series of delays and failures to follow agency policies and procedures contributed to Sacco's inability to determine the full extent of the abuse occurring in the Finn home. The unjustifiable inaction and delays in the case, the failure to even attempt to interview the children's father and crucial collateral witnesses, procedural irregularities, and a bungled execution of a court order culminated in an ineffective interview with the Finn children. We believe Sacco's decisions unwittingly enabled Nicole to prepare her home for outsiders and coach the children in what to say. We do not have concerns with how Sacco handled the August 17 home visit. But by that time much of the damage to the DHS investigation had been done.

We do not have concerns with how Sacco handled the August 17 home visit. But by that time much of the damage to the DHS investigation had been done.

After the home visit on August 17, Sacco and Avery simply dropped the ball. Sacco demonstrated no sense of urgency on the case, and Avery did not discuss the case with Sacco until the morning after Natalie died on October 25. That is a stunning failure for both Avery and Sacco.

We also do not believe Sacco's caseload adversely impacted her ability to work this case appropriately.

According to DHS's internal investigation, agency officials "identified areas of needed improvement" and made changes to its processes, practices, and information technology system.²²⁸ No recommendations for changes in statute or policy were identified in DHS's internal investigation.²²⁹ Among DHS's corrective actions, we believe the following four are relevant to the issues we have examined in our investigation of the assessment opened on May 31, 2016:

- If a staff or supervisor requests a motion to compel, they need to review it with a Social Work Administrator and the motion should be requested from the County Attorney's office within the first 20 days of an assessment.
- When a staff goes on leave and safety has not been assured, the case needs to be reassigned to a different worker.

²²⁸ DHS's Executive Summary, page 11.

²²⁹ DHS's Executive Summary, page 1.

- If a worker and supervisor cannot assure safety of the child(ren) within the first 20 days, they need to review the case with the Social Work Administrator.
- Addendums will be open no more than 20 days and only for reasons stated in policy.²³⁰

Although these improvements are a positive step in addressing some of the problems we identified, lingering issues remain. The above-mentioned improvements do not address Sacco's failures to contact the non-custodial parent, all necessary collaterals, and the reporter. Moreover, we found that the results from several of DHS's systemic reviews suggest that the above-described failures associated with the Finn case were not anomalous.

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In 2006, DHS officials conducted a statewide review of both the intake and assessment sides of its child welfare program. A summary document stated that one of the concerns identified on the assessment side involved a failure to interview all necessary collaterals.²³¹ The summary document did not elaborate.

The next review of its kind was conducted in 2017 in the aftermath of Natalie's death. Reviewers found several assessment-side concerns in 2017 that were identical to concerns found in the handling of the Finn assessment opened May 31, 2016:²³²

1. Field workers did not contact all necessary collaterals in 58 of 249 assessments reviewed (23 percent).
2. Field workers did not contact the reporter in 100 of 216 assessments reviewed (46 percent).²³³
3. Field workers did not contact the non-custodial parent in 60 of 177 assessments reviewed (34 percent).²³⁴
4. Field workers did not make timely contact with the child victim(s) in 21 of 249 assessments reviewed (8 percent).

Those findings suggest that several of the failures in the handling of the Finn assessment were systemic.

²³⁰ *Id.* at page 12.

²³¹ *CPS SYSTEM REVIEW STATE SUMMARY*, page 1.

²³² From *2017 Intake and Assessment Case Review April to December 2017*.

²³³ "It should not be that high at all," Armstrong told us, later adding, "We've added something back into our system now to remind staff that they need to recontact the reporter, possibly, for additional information."

²³⁴ Armstrong told us that it is not necessary to contact the NCP in all assessments. "In many cases the NCP may have not seen the child in years," he told us, "so there wasn't necessarily a reason or it wouldn't necessarily give you additional information there. So just comparing a number isn't necessarily appropriate."

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DHS officials conducted a similar review in 2019. With one notable exception, reviewers in 2019 again found several assessment-side concerns that mirrored concerns found in the Finn assessment.²³⁵

1. Field workers did not contact the reporter in 26 of 67 assessments reviewed (39 percent).
2. Field workers did not contact the non-custodial parent in 10 of 49 assessments reviewed (20 percent).
3. Field workers did not make timely contact with child victim(s) in 8 of 75 assessments reviewed (11 percent).
4. Field workers did not correctly open an addendum in 4 of 10 addendums reviewed (40 percent). This was a new issue which had not been included in any of the previous systemic reviews.

Those findings suggest that several of the failures in the handling of the Finn assessment were still systemic three years later. The notable exception involved the need to contact all necessary collaterals. The 2019 review found that field workers failed to contact all necessary collaterals in only 1 of 75 assessments reviewed (1.3 percent).²³⁶ That suggests systemic improvement by field workers on the need to contact all necessary collaterals. However, we believe it would be a mistake to conclude that the issue has been fully resolved, as DHS's 2019 review involved a much smaller sample size (75 assessments) than its 2017 review (249 assessments).

The Ombudsman recommends that DHS:

- 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.**
- 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.**

²³⁵ CPA Review of Accepted Intakes and Assessments, 1st Quarter 2019.

²³⁶ *Id.*

- 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 not 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.**

Three child abuse reports: September – October 2016

While Sacco's assessment was still on addendum, but before Natalie died, DHS received three additional child abuse reports involving the Finn family.

Under established DHS practice at the time of the Finn case, when a child abuse report was received about individuals who were already the subjects of an open assessment, the new intake was forwarded to the field worker and that worker's supervisor. It was then up to them to decide how the new intake should be handled. Rejected intakes handled in this manner were referred to as "urgent rejects."

SEPTEMBER 2, 2016, "URGENT REJECT"

DHS received a child abuse report on September 2, 2016, from the Principal at Walnut Creek Campus who had also made a report about Natalie in November 2015. This intake was handled by a CSIU intake worker.

According to the intake report, the principal raised concerns based on her experience with the Finn family the previous school year. She said that Natalie had often come to school hungry and dirty, and would knock on neighbors' doors asking for food. The principal had not had contact with the family since May so the only new information she shared was that Nicole had recently emailed the school to state that Natalie would not be attending school that year.

The principal told us that her purpose in making this child abuse report was "to let DHS know that we had all these concerns last year, and now this child has not returned to school, and we are fearful of her safety." She added, "I had reached out to Mom to see if she (Natalie) would come back to school and was told she wasn't going to come back, and intuitively, then, I just worried – all of us did – about what might be happening there."

The intake worker consulted SWS Allison, who decided to handle the intake as an "urgent reject" – meaning the intake was rejected but the information was conveyed to Sacco and Avery so they could review it and take any appropriate action. Allison also wrote, "JARVIS shows current open assessment ... with CPW Amy Sacco. Additional information for CPW Sacco."

According to the intake report, 17 minutes elapsed between the time the September 2 intake call ended and Allison's reject decision.

OCTOBER 5, 2016, "URGENT REJECT"

DHS received another child abuse report on October 5, 2016, from a counselor at West Des Moines Valley High School.

The counselor's report specifically concerned one of Natalie's siblings. The audio recording for this call shows that the counselor reported that the child "appears to not be eating" and looked "extremely thin, gaunt." The child told the counselor that they had to earn food by practicing good hygiene and keeping their room clean. But the child had not showered in a week and told the counselor, "I don't eat very much in my house."

The counselor further reported that the child had to ask permission to use the restroom in the middle of the night because Nicole thought they would “sneak water.” The child was given a time out when caught “sneaking water” the night before. The counselor said the child had already missed 14 days of school that year.

Toward the end of the call, the intake worker told the counselor:

Normally I would accept this for an assessment, but there’s already an open assessment. So I am going to take the information that you gave me and give it to the ongoing worker.... It’s kind of confusing, cause you’ll get a notice in the mail that says rejected but that’s because I’ve taken your information and added it to a current assessment.

The intake worker consulted SWS Allison, who decided to handle the intake as an “urgent reject,” as he had with the September 2 intake. Allison wrote, “Additional information to be addressed in current CPS assessment ... with Amy Sacco.”

According to the intake report, one minute elapsed between the time the call ended and the decision to handle it as an “urgent reject.”

OCTOBER 12, 2016, REJECTED INTAKE

The next child abuse report concerning the Finn family came in on October 12, 2016, from two administrative employees of the West Des Moines Community Schools.²³⁷

The intake was handled by an intake worker at CSIU who previously handled the May 27, 2016, child abuse report from the attendance caseworker. As the school counselor had in the prior report, the audio recording showed that the two school employees expressed concern about one of Natalie’s siblings, stating the child had not attended school since September 20, except on October 5 for a couple of hours. One of the them said the child had stated “that food was being used as a reward.”

Both school employees reported that Natalie had not been to school that year, and it was unknown what Natalie was up to and where she was. “We’re very concerned for where she is and what she’s doing and her safety,” added one of the them.

During the call, the other woman said, “We’ve reached out to Mom, she won’t return our calls.” She later added, “I’ve left countless messages and emails and with zero response.”

The intake worker asked where she had obtained the information that she was reporting. In response, the school employee said it came from the same school counselor who had made a similar report the week before. Notably, this was the first and only instance we found of an intake worker appropriately requesting the identity of a collateral witness.

²³⁷ Both employees’ job titles at that time were Learning Supports and Family Engagement Coordinator.

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The intake worker consulted SWS Noard, who decided to reject the intake. The rejection explanation was listed as “insufficient reason to suspect child denied adequate care.” However, unlike the two prior rejected intakes, this intake was not handled as an urgent reject, and so information about this intake was *not* emailed to Sacco or Avery.²³⁸ We were unable to determine whether the intake worker reviewed the family’s prior abuse history; but if she was aware of the open addendum assigned to Sacco, she made no mention of it in her intake report.

According to the intake report, 17 minutes elapsed between the time the call ended and the reject decision.

ANALYSIS

Sacco and Avery did not act on either “urgent reject”

Both Sacco and Avery received emails notifying them about the September 2 and October 5 intakes that were classified as urgent rejects. Sacco later told DHS that she did not see the September 2 email,²³⁹ but she remembered “physically reading” the October 5 intake.²⁴⁰

Avery confirmed with DHS officials that she received the September 2 and October 5 emails, but said she did not read them as she believed that was Sacco’s responsibility. “If they say ‘urgent reject’ I expect that the workers are following up on those,” Avery said. “I don’t necessarily review every urgent reject that comes through.”²⁴¹

Even if Sacco had reviewed the email and considered the information contained in the September 2 intake report, we are uncertain what action, if any, she should have taken. The only notable, new information was that Natalie was no longer attending school. On one hand, that contradicted what Nicole had told Sacco during the August 17 home visit (that Natalie would be attending 11th grade at Walnut Creek Campus for the new school year, which was just two weeks away). On the other hand, the issue of Natalie not attending school was not, in and of itself, a child abuse issue. DHS’s Employees’ Manual states:

Truancy alone does not constitute grounds for initiating a child protective assessment. The information must suggest that exceptional circumstances exist, such as a professional evaluation determining that a child has a special need to be in school because of a diagnosed disability....²⁴²

It is also worth noting that under Iowa’s truancy law, a child who turns 16 before September 15 of a particular school year is *not* considered to be of “compulsory attendance age.”²⁴³ Natalie was already 16 years old as of September 15, 2016.

²³⁸ Per DHS’s Executive Summary, page 8, XXXX was coached and counseled about the proper handling of urgent rejects.

²³⁹ During the interview, a DHS administrator informed Sacco that DHS officials had found the email in the email account assigned to Sacco. “That’s an email pulled from your email,” the DHS administrator said. Transcript of DHS’s interview of Sacco, November 1, 2016, page 32.

²⁴⁰ Sacco was out of the office on October 5 and did not return to work until October 10.

²⁴¹ Transcript of DHS’s interview of Avery, November 7, 2016, page 27.

²⁴² DHS’s Employees’ Manual, Title 17, Chapter A(4), Topic 8, page 8.

²⁴³ IOWA CODE § 299.1A.

Three Child Abuse Reports: September – October 2016

The October 5 intake was a different story, however. The report included new concerns about one of the Finn children’s physical appearance and access to food and water. During her interview with DHS, Sacco was asked if the allegations that the child appeared gaunt and having lost weight increased her sense of urgency:

Sacco: Again, it just ... I wanted to talk with the doctor. I wanted to see where the children were, you know, I don’t know what their size ... you know ... what ... from a medical standpoint.

DHS administrator: Right. You did not attempt to call this [reporter] back?

Sacco: No.

DHS administrator: Why?

Sacco: You know ... I don’t ... I don’t have an answer.

DHS administrator: Is there an allegation during the course of this and additional information that this child’s not allowed water? That [the child] has to ask permission to use the bathroom because mom thinks [the child] will sneak water?

Sacco: Yes.

DHS administrator: Is that concerning?

Sacco: Yes.²⁴⁴

Sacco acknowledged that she did not talk to Avery about the October 5 intake report. Asked why she did not discuss it with Avery, Sacco replied, “I don’t know. I guess, again, I still was just wanting the medical records.”²⁴⁵

After his phone call, the school counselor faxed a written report to DHS that stated in part that the child he had spoken to also said that “over the summer” Natalie and another sibling “would sneak out looking for food.”

The statement repeated information that the counselor had already provided to DHS over the phone but which was not documented in the intake report. Presumably, Sacco would have been responsible for reviewing the counselor’s written report, but we found no indication that Sacco was even aware of it.

The counselor told us, “They told me there was already an open case, so I felt pretty confident that they would take my information and proceed with it.” When we interviewed the intake worker, she described her mindset when she handled this intake: “I am looking just to get it in the door and out to the field, because if a [field worker] sees that kid and he really is as gaunt as he appears, there better be some action.” Sacco and Avery, however, took no action in response to the October 5 urgent reject.

Sacco and Avery, however, took no action in response to the October 5 urgent reject.

²⁴⁴ Transcript of DHS’s interview of Sacco, November 1, 2016, pages 26-27.

²⁴⁵ *Id.* at page 34.

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Urgent reject dispute

We were unable to find any written policy in the intake-related chapters of DHS's Employees' Manual about the practice of forwarding new child abuse reports on open assessments to both the field worker and that worker's supervisor. But there is a written policy about urgent rejects in the assessment-related chapters of the Employees' Manual. That policy states:²⁴⁶

- If exactly the same child victim and alleged person responsible are identified, consult with your supervisor. (Example: Denial of critical care is the initial allegation and presence of illegal drugs in a child's body is added as an additional allegation during the assessment.)

Incorporate the additional allegations into the current assessment unless there is not enough time to evaluate the additional allegations before completing the Child Protective Assessment Summary... In that case, treat the additional allegations as a new case.

- Incorporate an allegation regarding a sibling into the current assessment when the original victim and the sibling have the same parents and the person alleged responsible is the person named in the original allegation or is the other parent.
- If exactly the same child victim and alleged person responsible are not identified, treat the additional allegations as a new case. (Example: A different non-parent person responsible is named regarding a sibling.)

The same policy adds, "Additional subjects rather than additional reporters determine when a new assessment is required."²⁴⁷

During our investigation, we became aware of a dispute between DHS administrators and Avery and Sacco about the handling of the September 2 and October 5 intakes. In interviews with DHS and with our office, Avery contended that handling these two intakes as urgent rejects was not consistent with agency practice at that time. Avery said it was appropriate to reject a new intake to an assessment, but asserted that a case on addendum was technically a closed case, and staff should not reject a new intake to a closed case.

Our interview of Avery included the following exchange:

Ombudsman: I think you even acknowledged that it was closed, but then it was reopened. I mean it was in an open status.

Avery: It was not in an open status.

Ombudsman: You're saying today, that was a closed case?

Avery: It was a case that closed – so you have the allegations that you're dealing with in that case, and that is what you have the authority to pursue on. If new allegations come in – and these would be new allegations. If new allegations

²⁴⁶ DHS's Employees' Manual, Title 17, Chapter B(1), page 36.

²⁴⁷ *Id.*

Three Child Abuse Reports: September – October 2016

come in that would constitute abuse, those would have to be opened in a separate case.

Sacco made the same argument during her interview with our office.

Regarding the October 5 urgent reject, Avery told us that although the allegation was similar in nature to the allegations Sacco was dealing with, it should have been handled as a new assessment because the allegation that the child was not being allowed to eat and drink was new. Avery added:

My worker had met with that child prior to this allegation being made, and the child was gaunt and appeared to have lost weight as a result of that. So this, to me, would be a new allegation, because it requires new actions by the CPW. In this case it was rejected outright and was sent on as information only with no new observation time frames, which means it was not even being accepted as new allegations to be added on to an open case, which you can do as long as that case is less than two weeks old. So those are the parameters of what we were working under at that time.

The intake worker who handled the October 5 intake told us she was surprised that the field did not act on this “urgent reject.” “I had no reason to believe that it would not be addressed, because this is something in the field that I was required to do by my supervisor,” she said. “I was not aware that there were different practices in place.”

As explained earlier in this section, field workers are responsible for determining if the additional allegations identify the same child victim and the same person allegedly responsible.²⁴⁸ If that happens, the same policy instructs field workers to consult their supervisor and to incorporate the additional allegations into the current assessment unless there is not enough time to evaluate the additional allegations before completing the Assessment Summary.²⁴⁹ That policy appears to contradict Avery’s explanation of why the October 5 intake should have been accepted and treated as a new assessment.

Avery also argued that because of the workloads she and Sacco were both juggling at the time, it was not reasonable to hold that they should have reviewed the October 5 urgent reject and alerted other agency officials if they thought it had been mishandled.

We asked DHS administrators about Avery and Sacco’s assertion that CSIU staff mishandled the September 2 and October 5 intakes. In response, DHS administrators stood by their decision that these two intakes were handled appropriately and in line with agency practice at that time, stating:

The rejected intakes would have been received by the worker and their supervisor in the form of an email with a subject line of “URGENT REJECT” and case

²⁴⁸ DHS’s Employees’ Manual, Title 17, Chapter B(1), page 36. All four children were identified as the victims in the addendum assigned to Sacco. Nicole was identified as the alleged perpetrator in both the addendum and the October 5 urgent reject.

²⁴⁹ *Id.*

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number. The worker and supervisor were responsible for reviewing the email to determine all allegations needing to be addressed by the worker of the current open case, regardless of whether the rejected intake contains new allegations or not. Rejected intakes with similar allegations are just as important as they could provide new collateral (*sic*) to contact, they bring more current concerns to the attention of the worker and supervisor, and multiple reports on a family and situation would cause a heightened sense of urgency to address concerns on the case. Though Ms. Avery states, “I’m not going to sit and open every urgent reject that comes through,” that is not the practice of other supervisors and is not in line with DHS practice and procedure. In addition, Ms. Avery also stated, “Yes, of course, I expect my workers to look at them,” confirming that there is a need to review these rejected intake emails....

Regardless of Ms. Avery’s assertion that CSIU mishandled these intakes, she and her staff person were notified of the reported concerns and had a responsibility to ensure those concerns were considered.

We are not able to settle the dispute as to how these two rejected intakes should have been handled. Regardless, we believe Avery and Sacco had a duty to read and act on the emails or notify intake staff that the intakes were handled incorrectly.

Information not documented

We are unable to evaluate the completeness of the September 2 intake. Although this intake call was received during normal business hours, CSIU staff later discovered it was not recorded as is the practice due to an equipment failure.

We did, however, obtain and review the audio recordings for the two October intakes. As with the pre-assessment intakes reviewed earlier in this report, we found similar concerns. Some important information provided by the reporters was not contained in the intake reports.

During the October 5 intake call, the school counselor related what the child had told him about needing Nicole’s permission to use the restroom at night. The counselor quoted the child as saying, “Well she thinks we’re going to drink it out of the faucets, and we need to ask for water.” That statement was translated in the intake report as only pertaining to the child:

[The child] has to ask permission to use the restroom in the middle of the night because mom thinks [the child] will “sneak water” and was caught last night “sneaking” water and mom gave [the child] a timeout. Fell asleep during time out at 0430. That is why [the child] was late to school after missing bus.

The intake report failed to capture the implication that the child may not have been the only child with potential issues involving hydration. We believe the statement that “we need to ask for water” should have been documented.²⁵⁰

²⁵⁰ As mentioned earlier in this report, a daycare worker told our office that ten years earlier Nicole directed daycare staff not to give her children water because they could get water poisoning.

Three Child Abuse Reports: September – October 2016

The school counselor also recounted the child’s statement about Natalie and one of the other siblings sneaking out of the house over the summer to find food:

“My Mom doesn’t trust us because [Natalie and another sibling] ... snuck out at night to try to find food ... and were telling people that they didn’t have enough food.”

That statement was documented in the intake report as, “Two younger children are home schooled.”

The intake worker told us that she thought the rest of the statement about food was already known to Sacco. During the August 17 home visit, Natalie told Sacco that she was addicted to junk food, making her action appear to be caused by her own bad habits and decision-making. The information that the school counselor provided indicated the situation was much more serious than previously known.

The audio recording from the October 12 intake indicates that the intake worker spoke with both women during the call, and both expressed concerns about two of the children, including Natalie. The intake report only identified one reporter.

In response to our inquiry, DHS officials acknowledged that both individuals should have been identified as reporters. “Best practice is to ask each person on the call if they want to be listed as a reporter and then to indicate all reporters in JARVIS,” DHS officials stated. During this intake call, the intake worker did not ask the two school employees if they wanted to be listed as reporters.

“It’s a frustrating process, I guess, when you suspect or have that, you know, gut feeling that something’s not right and just kind of feel helpless.”

One of the school employees told us, “It’s a frustrating process, I guess, when you suspect or have that, you know, gut feeling that something’s not right and just kind of feel helpless.” She later added, “It was just about a week later that she passed after our call, I just remember feeling like if they just maybe would have gone out to see the child or accepted our report, I mean it could have been, obviously, a much different outcome.”

CONCLUSIONS AND RECOMMENDATION

As with other intakes involving the Finn family, accurately documenting information continued to be an issue in two of these three intakes.

We agree with DHS’s determination that the October 12 intake was appropriately rejected. We were not, however, able to settle the dispute as to how the September 2 and October 5 intakes should have been handled. The real problem was that neither Sacco nor

By that time, Sacco was doing very little work on the case, meaning the addendum and the urgent reject were both neglected.

Avery took any action on the information contained in the October 5 intake. This information could have affected how the case on addendum was handled. By that time, Sacco was doing very little work on the case, meaning the addendum and the urgent reject were both neglected.

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We agree with DHS's assertion that it was Avery and Sacco's responsibility to ensure all information was reviewed and considered for the safety of the Finn children.

After their internal review of the Finn case, DHS officials modified the practice for handling child abuse reports about individuals who are already the subjects of an open assessment or addendum. DHS's internal investigation stated:

Intake no longer rejects intake information to an open addendum. The processing of an intake decision is no longer affected by whether there is an open case or open addendum. Intake no longer assigns new information to an open case. The decision to accept or reject will be made, and all accepted cases are opened for assessment without regard to current open cases.²⁵¹

This change is further described in the materials for a DHS training course that directs staff to accept allegations for assessment when there is a current open assessment if “[s]tanding on their own merit, the allegations meet legal criteria for acceptance.”²⁵² The same document adds:

New allegations accepted at intake on current open assessments will be “linked” to and auto-populate into the current open assessment, and will include new observation timeframes.

The Ombudsman recommends that DHS:

- 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.**

²⁵¹ DHS's Executive Summary, pages 11-12.

²⁵² *SP 810*, page 97.

Natalie's death and DHS's final assessment

A lot of information about the final weeks of Natalie's life came out in her adoptive mother's criminal trial, which received extensive media coverage. Witness testimony, particularly from the children themselves, painted a disturbing picture of the Finn household. We will not retell all of the details that were revealed in the trial or in the assessment DHS conducted after Natalie's death, but it is important to understand what was actually happening in the Finn home.

Two child abuse reports were made to DHS after Natalie went into cardiac arrest on October 24. In the first report, West Des Moines Police Officer Chelsea Dexter said Natalie was thin and malnourished, and it appeared that Nicole was not providing Natalie with adequate food. Natalie was found wearing an adult diaper in a room with no carpet and a few blankets. The report was accepted for a child abuse assessment, which was assigned to an after-hours field worker instead of Sacco, whose case was still on addendum.

Officer Dexter reported to the field worker that when she had offered to get food for Natalie's two biological siblings, they were reluctant to accept unless Nicole gave them permission. After receiving permission from Nicole, Officer Dexter wrote that she "went to the closest McDonald's and got the kids some food."

The field worker noted in her report that Nicole, who had been speaking with WDMPD detectives, became defensive when the field worker introduced herself. The field worker conducted a walk-through of the home, which she described as "very chaotic," with barking dogs in kennels, numerous cats running in the home, litter boxes located throughout, and one room designated for sick cats. She also observed that the room the children shared had linoleum flooring and no furniture. Detective Tom Boyd told the field worker that when he was in the home in August, there was carpet in the room and the condition of the home was "not this bad."²⁵³

Natalie's three siblings were taken to a hospital, over Nicole's initial protests, to be seen by a medical professional. At the hospital, the field worker noticed a stark difference in appearance between Natalie's two biological siblings and Natalie's adoptive brother, who soon after was discharged from the hospital to Joe's care. Natalie's two biological siblings, on the other hand, were admitted to the hospital and determined to be too medically fragile to be transported for a forensic interview.

The second child abuse report made that evening came from a social worker at Blank Children's Hospital, who reported Natalie's weight at approximately 70 pounds, and saying she had weighed 120 pounds the year before. The report was rejected because it was a duplicate of the report that had already been accepted for assessment.

²⁵³ Detective Boyd was one of the officers who accompanied Detective Kincaid and Amy Sacco to the Finn residence on August 17, 2016.

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Natalie's biological siblings stayed at the hospital for more than two weeks, where they were put on 3,000–3,500 calorie diets and gained 14 and 15 pounds, respectively. That was despite Nicole's comments to the children about their food choices when she would visit them.

DHS began to learn more about life inside the Finn home. Nicole required the three biological siblings to get permission before they could leave their room, but they were not allowed to wake her up if she was sleeping, which was often due to her medical issues. As a result, they were rarely allowed to walk from their room to the bathroom. After the beds and carpet were removed, the children were left with only a linoleum floor to sleep on with a blanket and pillow.

Confined to the room, the children learned to tell the time by the location of the sun on the wall, and the date by the tornado sirens that went off at noon on the first Saturday of each month.

Nicole would not allow the children to eat unless they asked for food. One of the children testified at the criminal trial that when Nicole ignored their requests, they just gave up asking. At some point, one of the children put up a sign in the bedroom window that read, "Need food and money."

Natalie stopped eating on her own sometime after the August 17 visit by Sacco and law enforcement, even though food and water were offered to her. In the weeks before her death, Natalie first needed help standing up. Then she needed help walking. Eventually, Natalie needed help eating. She was given sugar water, high-calorie milk shakes, yogurt, caffeine water, and corn syrup, which Natalie took at first, but then stopped. No one could explain why Natalie stopped eating, but Nicole did not take her to a doctor out of concern she would get in trouble for Natalie's condition.

The field worker placed the assessment on addendum on November 21 and it was subsequently approved for closure on December 28, 2016. It featured a total of 12 founded child abuse allegations against Nicole and six founded child abuse allegations against Joe. DHS placed all 18 founded allegations on the Child Abuse Registry.

The 18 founded child abuse allegations for denial of critical care broke down as follows, with Natalie and her two biological siblings as the victims.

- Nicole had three founded allegations for failure to provide adequate food to the extent that there is a danger of a child suffering injury or death.
- Nicole had three founded allegations for failure to provide adequate health care to the extent that there is danger of a child suffering injury or death.
- Nicole and Joe both had three founded allegations for failure to provide adequate shelter to the extent that there is danger of a child suffering injury or death.

Natalie's Death and DHS's Final Assessment

- Nicole and Joe both had three founded allegations for failure to provide for the adequate supervision of the child that a reasonable and prudent person would provide under similar facts and circumstances when the failure results in direct harm or creates a risk of har to a child.²⁵⁴

We did not identify any procedural or efficiency problems by DHS staff after Natalie's death.

²⁵⁴ IOWA ADMIN. CODE r. 441 – 175.21. “Proper supervision” means that supervision which a reasonable and prudent person would exercise under similar facts and circumstances, but in no event shall the person place a child in a situation that may endanger the child's life or health, or cruelly or unduly confine the child.

Additional concerns identified during the investigation

Our report up to this point has focused on the immediate facts and issues related to the child abuse intakes and assessments involving the Finn family. We would be remiss, however, not to address several systemic problems we found with both the intake and assessment sides of DHS's child protection services.

INCREASES IN CALL VOLUMES AND ACCEPTED INTAKES

We requested and received figures from DHS for the annual number of child abuse reports from 2000 through 2018. In 2016, the year Natalie died, DHS received 49,066 child abuse reports, which at that time was the third highest annual total since 2000. Child abuse reports increased the following year by 11 percent to 54,362, and 2018 saw an additional 4 percent increase to 56,552 reports. The 2017 and 2018 totals were the highest in the 2000-2018 period.

Those increases followed intense media coverage of DHS's handling of the Finn case and the death of Sabrina Ray, as well as a 2017 change in state law which expanded the definition of child abuse to include more drug-related cases.²⁵⁵

In addition to the increasing numbers of child abuse reports in 2017 and 2018, these years also saw an increase in the percentage of reports accepted for assessment.²⁵⁶ In 2017 and 2018, the combination of increasing report numbers and acceptance rates of around 62 percent resulted in record numbers of reports accepted for assessment.²⁵⁷ A record 33,418 reports (61.5 percent) were accepted for assessment in 2017. In 2018, a new record of 35,029 reports (61.9 percent) were accepted for assessment.²⁵⁸ For comparison, the national average for accepted intakes was 58.2 percent.²⁵⁹

²⁵⁵ An article published May 29, 2018, by the Des Moines Register, titled *Confirmed child abuse in Iowa is skyrocketing*, described the law change: "The legislation required Human Services to investigate more allegations of children exposed to illegal hard drugs. Accusations of any adult in a home who reportedly was using, possessing, making or distributing methamphetamine, cocaine, heroin or opiates in the presence of a child became criteria for accepted abuse reports. Before that change, the agency only had to accept drug-exposure allegations involving parents and guardians involved with meth."

²⁵⁶ That percentage had generally exceeded 60 percent from 2000 to 2011; then it hovered between 49 percent and 55 percent from 2012 to 2016.

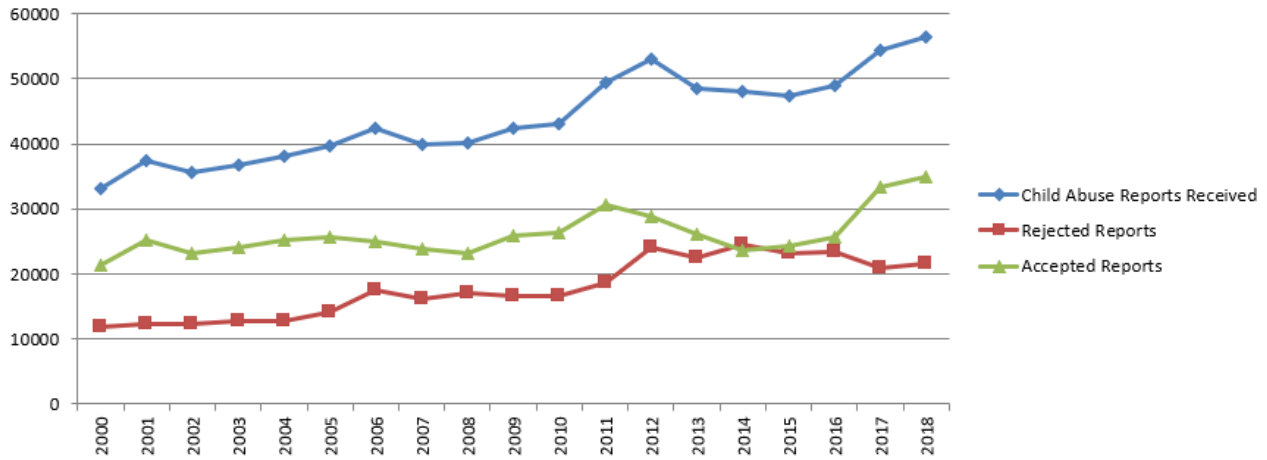
²⁵⁷ Acceptance rates hovered around 49 percent and 59 percent from 2012 to 2016.

²⁵⁸ The 2018 figure was an astounding 36.3 percent higher than the 2016 figure of 25,707 reports accepted for assessment; and it exceeded the total number of reports received in 2000 (33,193).

²⁵⁹ CWG's report, *Initial Targeted Child Welfare Review*, December 22, 2017, page 10. We arrived at the 58.2 percent screen-in rate based on the report's national screen-out rate of 41.8 percent.

Additional Concerns Identified During the Investigation

*Child abuse reports received, rejected and accepted 2000-2018*²⁶⁰



As a result of changes DHS officials made after their review of the Finn case, intake staff was retrained to accept cases instead of rejecting them whenever an intake decision is borderline or questionable.²⁶¹ “There was an extreme shift (toward) accepting intakes,” one former intake worker told us.

“It’s kind of like when we had the Shelby Duis case,” another former intake worker told us. “We were working one way, and so we swung the pendulum all the way to the other side.... Now with the Finn case, we’re doing the same thing again.”

When interviewed, CSIU officials told us that DHS administrators have not voiced any concern about the recent increase in acceptance rates.

DHS officials believe one other factor contributed to the increased rate of accepted intakes in 2017 and 2018. DHS’s Child Abuse Registry Annual Report, issued in December 2018, stated that the increase stemmed in part from a change in how DHS handled additional reports received when there was already an open child abuse assessment. Prior to 2017, DHS officials told us, additional allegations were often added to an open child abuse assessment. From February 2017 through September 2018, they said, a change in practice required a separate child abuse assessment for any additional allegations that were accepted. According to DHS’s 2018 Child Abuse Registry Annual Report:

This practice was temporary until an update to the child welfare information system ... could be implemented to allow additional allegations to be formally linked to the open child abuse assessment; no longer requiring a separate report.

²⁶⁰ For precise data regarding the annual number of reports received, reports rejected and reports accepted, see Appendix C.

²⁶¹ DHS’s Executive Summary, page 11.

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In its 2017 report, CWG issued the following warning:

(T)he broadening of intake and the lowering of screen-out rates, are familiar; they follow a pattern often taken by states in the wake of child fatalities or other high-profile cases in well intentioned attempts to ensure children’s safety. They have, however, in the reviewers’ experience, seldom if ever had the intended effect. Such actions can, in fact, serve to place more children at risk by adding to workload requirements that are frequently already overwhelming and broadening the scope of intervention far beyond the expertise or experience of child welfare personnel.²⁶²

“Such actions can, in fact, serve to place more children at risk by adding to workload requirements that are frequently already overwhelming and broadening the scope of intervention far beyond the expertise or experience of child welfare personnel.”

During our interview of Vern Armstrong, administrator of DHS’s Field Operations Division, we asked about CWG’s warning. Armstrong acknowledged that the child welfare system tends to have pendulum swings, and high profile cases often lead to changes that result in more cases being accepted. “If the state is sensed as being too heavy handed, the pendulum swings back,” Armstrong told us. “So [CWG] were very worried about us starting to accept a lot more reports.”

Former DHS administrator Wendy Rickman also addressed the issue of increasing case numbers. “So for us it was always a discussion about how seriously do you take child safety and when, in trying to figure out how serious you’re going to be, you start to lose effectiveness, either because you’re overburdening the system or you’re involving families that you’re not going to help and really probably didn’t need to see you to begin with.”

Armstrong said that while the acceptance rate has increased, that rate is still within the recommended national standard. He also noted that the rate of founded abuse cases has stayed relatively steady, which in his opinion means DHS has not been accepting a lot of extraneous cases.

SIGNIFICANT INCREASES IN FIELD WORKERS’ AVERAGE CASELOADS SINCE THE FINN CASE

Similar to intake workers, field workers’ average caseloads also increased significantly in the two years following the Finn case. In 2017, then-Director Jerry Foxhoven told the Iowa Council on Human Services that he had been talking with field workers to assess their needs. “Morale is not good, as I’m sure you can imagine,” Foxhoven said. “Their caseloads are somewhat high and they’re just bureaucratically worn out by the bureaucracy that we have.”²⁶³

²⁶² CWG’s report, *Initial Targeted Child Welfare Review*, December 22, 2017, page 20.

²⁶³ Article on Iowa Public Radio website, “DHS’s Foxhoven: Morale ‘Not Good’ Among Child Abuse Investigators” October 11, 2017.

Additional Concerns Identified During the Investigation

The number of assessments assigned to field workers statewide increased from 25,707 to 35,029 from 2016 to 2018, a staggering 36 percent.²⁶⁴ Referring to that increase since the Finn case, SWA White told us, “The higher caseloads have been a challenge for our workers.”

Armstrong told us that in response to the significant increase, “that’s why we’ve been adding in Social Worker 3s.”

Before 2019, the number of DHS child-welfare-related employees had generally been going down for most of the past decade. The number bottomed out around October 2018, when the total number of workers was 16 percent lower than in January 2012.²⁶⁵ The number of Social Worker 2s was 19 percent fewer than in 2012²⁶⁶ and the number of support staff was 31 percent fewer than in 2012.²⁶⁷

Bucking the trend was the number of SW3s (combined total of field workers and intake workers), which grew by 2 percent from 2012 to October 2018.²⁶⁸ That was no accident, as DHS administrators said they tried to protect SW3 staff from the cuts impacting the rest of the child welfare program.

During this period, DHS officials occasionally described the impacts of having fewer child-welfare-related employees in reports to federal child-welfare officials. A federal report issued in 2017 included a section written by an Iowa DHS official which stated in part, “Iowa’s child-protection workforce must meet the challenges of increased pressure on slim resources.”²⁶⁹

Another DHS report to federal child welfare officials in 2018 stated:

The continued economic downturn in Iowa’s economy resulted in mid-year budget cuts for state fiscal year (SFY) 2018. While DHS was able to absorb the SFY 2018 mid-year cuts, it is unclear at this time what the impact will be of the reduced DHS budget for SFY 2019. DHS will continue to strategically incorporate funding cuts in a manner that reduces the impact on programs and services provided to Iowa’s children and families. However, continued cuts over the last several years leave the department with reduced options to absorb any future cuts without impacting programs and services.²⁷⁰

When we interviewed Armstrong, he recalled a conversation that occurred sometime in 2017 or 2018: “The first year Director Foxhoven came in, I was projecting a very large deficit, and we

²⁶⁴ Although Polk County field workers have seen their caseloads go up significantly since the Finn case, their average caseloads in fiscal year 2018 (July 1, 2017, to June 30, 2018) were less than the statewide average caseload.

²⁶⁵ According to information we received from DHS, the agency had 885 child-welfare-related employees as of January 19, 2012; and 745 such employees as of October 4, 2018.

²⁶⁶ DHS employed 360 SW2s as of January 19, 2012; that number had shrunk to 291 as of October 4, 2018.

²⁶⁷ DHS employed 227 child-welfare-related support staff as of January 19, 2012; that number had shrunk to 157 as of October 4, 2018.

²⁶⁸ DHS employed 200 SW3s as of January 19, 2012; that number had gone up to 204 as of October 4, 2018.

²⁶⁹ Children’s Bureau of the U.S. Department of Health and Human Services, *Child Maltreatment 2017*, page 160.

²⁷⁰ DHS, FFY 2019 APSR (Annual Progress and Services Report), June 29, 2018, page 5.

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were going down, and the director basically said, ‘Stop. We can’t lose any more field workers. We’ll have to find the money somewhere. We’ll do something, but stop.’”

The year of 2019 could go down as the year when things turned around for DHS’s child welfare program. DHS’s July 18, 2019, letter to our office stated:

Funding for field operations has increased by approximately \$10.8 million from SFY 19 to SFY 20.... We are currently hiring 11 SW3’s, 29 SW2’s and 3 SW Supervisors.

... DHS advocated for additional social work staff, the Governor included additional funds for social work staff in her budget recommendations, and the General Assembly appropriated additional funds for SFY 20. The increase of additional social work staff to meet national standards is expected to take a multi-year effort.

Armstrong explained to our office, “This year (2019) the Governor put additional money in her budget (for an additional 29 FTE’s). The legislature, then, gave even additional money on top of that (\$1.7 million) ... for field operations specifically, so we’re on a trajectory back up right now.” He added, “This is not a one-year plan to increase staff. The director has put together a plan over the next four years to continue to increase staff to get us closer to those national standards.” This statement came about a month before Jerry Foxhoven left as director of DHS.

INSUFFICIENT CSIU STAFFING

Intake worker positions remain static

When CSIU received its first child abuse report in 2010, it employed 21 intake workers. By 2011, DHS had allowed CSIU to expand to 23 intake worker positions. That number has not changed in the subsequent eight years.

Unit administrator Geyer told us that the increased call volume in recent years is manageable “if everybody is here, all 23 workers.” He then added, “But as soon as three of those people are gone – I mean, it’s staffed pretty tight, I’ll say that.”

“We were staffed at bare minimum,” Service Area Manager Lipscomb told us when we interviewed her. The unit was built to operate with 23 intake workers, but has not usually been at that level due to vacations, sick leave, and turnover. “I don’t know if the time off thing was accounted for when the 23 number was given,” Geyer said.

Most told us they believe at least three to five additional intake workers are needed.

Nearly everyone we interviewed said that CSIU needs more staff. Most told us they believe at least three to five additional intake workers are needed. “I believe that we need to have more staff, better coverage during very busy times,” said one CSIU employee. “I believe that there needs to be more review of work, and in order to do that there needs to be more bodies.”

Additional Concerns Identified During the Investigation

Unit administrator Geyer told us he would welcome more intake workers but said he was uncertain whether they are needed. He explained:

It's hard for me to remember a time when we actually were completely fully staffed for a period of time that was long enough for me to say this increase, we can handle that increase, with the 23 people.... So I want to get there to really say, OK, can we? I don't know if I can answer if we need more. I could always use more just because I know people are gone and that would also help with any time we have turnover, which seems to be – it takes a while to get people hired. The last couple years we've not been fully staffed for a very long period of time.

Since CSIU's inception in 2010, DHS officials have never requested an increase in funding specifically for CSIU operations.²⁷¹ “[W]e all feel the stress of the budget constraints,” one CSIU employee told us. “In an ideal world, we definitely need more workers ... but we also know that because of budget purposes, that's just not something we can have right now.”

We asked Geyer if he has ever made a request to increase the number of intake worker positions. Geyer said, “I have not specifically asked or talked about that. Mostly because it's just – we just know we're just not gonna get any.” When we asked how he knows that, Geyer replied, “It's not been a specific conversation, but that's just the sense I get.”

Lipscomb put it this way: “With a status-quo budget, there's nothing to ask for. There's no money for additional positions.”

Instead of asking to expand that number, Lipscomb said she has focused on trying to prevent any reductions to the 23 intake worker positions. “We're kind of always trying to figure out how to cover for positions,” Lipscomb said. “I've advocated let me keep them full versus asking for more, even though I would like to have a few more over and above the 23 for that very reason, just because we always have turnover, and we also have to let people take off.”

Absences impact daily operations

When a new workday begins, it is not unusual for intake workers to take a quick inventory of how many colleagues are gone that day. One intake worker told us that a higher number of absences “means that we might have to take more phone calls if it's a busy day, so that's always kind of been an issue throughout the years.”

For this reason, the unit's practice has been to allow no more than three intake workers to have a pre-planned absence on the same day for things like vacations and trainings. “That's been that way since even before I got there,” said unit administrator Geyer.²⁷² “That's the number that, okay, so if we let three people go we could still function operationally okay. But then you allow three people off and two more people call in sick, and then you're down [five]. That happens - more common than I'd like it to.”

²⁷¹ DHS letter from Mikki Stier, November 8, 2018.

²⁷² Geyer told us that his employment at CSIU began in 2012, when he was hired as CSIU administrator.

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Our interview of one former intake worker included this exchange:

Ombudsman: It's my understanding that trying to schedule a family trip, for example, six weeks out –

Former intake worker: It's not going to happen.

Ombudsman: – was hard at CSIU.

Former intake worker: Probably, depending on the year, like the time of year, it's not going to happen like that. More along the lines of six months out, maybe even a year.

SWS Noard, who is one of only four supervisors, explained that the need to minimize absences does not apply just to intake workers. “We have to have enough administrators in the building to be able to give decisions and review intakes and keep things pushing along,” Noard said. “We just simply don't have the affordability to have extra people gone.”

Staff turnover

In 2016, DHS records show, three people left the job of intake worker at CSIU. But in the two-year period of 2017 and 2018, at least 10 people left the intake-worker job. That included three people who had handled an intake involving the Finn family.

While five of those open positions were filled within two months or less, DHS records show it took more than three months to fill three of those openings.

We found that the spike in turnover has had a significant detrimental impact on CSIU's daily operations. A CSIU's staff meeting agenda from March 2018 stated in part:

It has been really stressful here!! The call volume really hasn't changed but the number of staff here to take those calls is down. If everyone here takes around 10+ calls a day and we are down 4 open positions, that is 40 calls that have to be distributed amongst everyone here. The new staff will be starting soon so hopefully we will see some relief in the next couple of months but we appreciate all of the hard work everyone puts in every day!!

When we interviewed members of CSIU's management team two months later, in May 2018, the unit still had only 18 intake workers. SWS Allison told us:

Unfortunately I would say morale is low due to workload, turnover, not having full staff. We haven't been fully staffed for quite a while, or if we have been, it's been for a brief period of time.... When we're fully staffed and things are running smoothly, it can be going very well; but in times of being down workers, workers calling in sick, being low staffed, and the work is still there, it definitely takes a toll.

Additional Concerns Identified During the Investigation

An intake worker we interviewed agreed: “If we have open positions and they’re not being filled quickly, that can kind of bring the morale down because we know that we’re going to be more busy; there might be issues with taking vacation time or time off.”

OPERATIONAL IMPACT OF INSUFFICIENT CSIU STAFFING

Hold times increasing

We found that CSIU management made a priority of answering phone calls quickly in 2015 and 2016. Geyer told us that the goal was to keep average hold times under one minute. Otherwise, he said, “You’re gonna lose people and we don’t want to lose anybody.” Geyer told us that the expectation was a 45-second hold time, which was established before he got there.

When we asked a former intake worker what the goal was for managing the queue prior to Natalie’s death, she replied:

As quick as you can, get off the phone and get back on the phone. The problem is then you don’t have enough time to get those previous intakes written up and get them to a supervisor.... So if you were getting a lot of calls, then you would get backed up on getting them written up and not getting them out.

Since the establishment of CSIU, intake workers have generally been provided 15 minutes of work time after they receive a new intake call. The purpose is to allow intake workers an opportunity to process the new intake before they are expected to take another call (unless there are no other calls at that time). The 15-minute allotment is not a hard-and-fast limit; intake workers can exceed the 15 minutes and often do. “We want them to get as much done as they can in that 15 minutes,” SWS Noard explained. “We know that’s not always practical to get everything done in that 15 minutes.”

When the 15 minutes expires, the intake worker can continue to work on that intake or previous intakes, but with an important caveat: They must be ready to take a new call at any time. This is referred to as “ready status.”

Typically, new calls go to intake workers who are not busy processing a prior call during their 15-minute work times. Before late 2016, however, that was not the case during “peak call volume” times, in which all intake workers were either on a call or in their 15 minutes of work time. To keep hold times to a minimum, supervisors would sometimes route new calls to intake workers who were not done with their 15-minute allotment from a prior call. CSIU staff refer to this as the intake worker being “thrown back in.”

By the end of a day with heavy call volume, most intake workers were “thrown back in” at least once so callers would not have to wait on hold for more than a few minutes. Depending on the frequency, being “thrown back in” could lead to “stacking intakes,” where a worker accrued several intakes (or more) which still needed to be processed.

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The following exchange occurred during our interview of a former intake worker on the effects of being thrown back in:

Ombudsman: When you were in that mode of processing the intake, how common was it to be interrupted and be put back into a new call?

Former intake worker: 50/50.

...

Ombudsman: When you got those interruptions, what kind of an impact did that make on your ability to properly process that first one that you have to park to the side?

Former intake worker: Very distracting.

The same former intake worker said she once had 12 “stacked up” intakes. Another former intake worker told us she once had as many as 16 stacked intakes. She added:

If it’s a high-volume day, you could be sitting there and you’re high on the process line because you’ve already stacked them up. You’re already stacked five or six or eight calls that you’re trying to process, and then all of a sudden your phone is ringing ... and supervisors are plugging you in.

She later added, “They would say, ‘There’s calls in queue so you need to take them.’”

“I don’t care how good you are, confusion is going to set in because it’s like, oh, was that detail on this one or was it on the third one.”

When we asked whether that had an impact on her ability to make the right decision on those intakes, the former intake worker replied, “It’s hard because the longer it’s stretched out that you’re processing, some of those details get a little fuzzy because here you are, you’re stacked up six or eight, so confusion starts setting in. I don’t care

how good you are, confusion is going to set in because it’s like, oh, was that detail on this one or was it on the third one.”

When intakes “stacked up,” intake workers were expected to prioritize those intakes. Noard explained why:

By the time we’re an hour or two in to especially an accepted intake, we really need to be getting that thing done and out.... [Y]ou may be working on multiple intakes, but we have to prioritize them and we have to get out the important stuff first, because we can’t have a big delay because the field time frames are strict, and we don’t want them to miss a time frame because we didn’t get them out of our unit fast enough.

Hold times have increased, however, since Natalie’s death. Unit administrator Geyer acknowledged that they could not maintain the average 45-second hold time. He said the average hold time now is just under two minutes “which isn’t where we were and where we’re kind of expected to be. But given the increase in (call

Hold times have increased since Natalie’s death.

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volume), no staff has been increased ... that's kind of where we're at." Geyer said that on a busy day, some isolated calls could be on hold for 10 or 12 minutes. "And I think that makes everybody a little nervous," he said.

Speed versus quality

CSIU's intake workers struggle at times to manage the push and pull of trying to document as much as possible for the intake they are working on, all the while knowing they need to move on to the next call as soon as possible. We believe pushing workers to process intakes quickly may have been at least part of the reason for the widespread policy noncompliance we found regarding the intakes involving the Finn family. One CSIU employee told us:

When the call volume is very high, it is a lot easier for workers to miss things or forget to put something in, and then you'll have to say, "Hey, where is this? I don't see it." They're like, "Oh, goodness. I totally was just in a hurry and forgot." So, yeah, as call volume increases, we see more mistakes that are made.

"Any time you're multitasking, it takes away from your ability to perform to your best ability," observed SWS Allison. One intake worker acknowledged a connection between the problems we found with her handling of an intake involving the Finn family and the need for speed at CSIU:

I can't tell you exactly when that started as far as just being stressful and pressure, but I do know there's been more lookups and more responsibilities and pushing at doing it fast. You're working on one, and they're throwing you on another call, and sometimes you're even working on a one-hour, and you're getting a call ... you've just got to do what you can, but you've got to prioritize the one-hour. You can have two or three going at once, or more.

Not everyone we interviewed agreed. "I think that we could use more time," a current intake worker told us, "but I don't think that I've had to compromise my quality ... to get things done."

When we asked a former intake worker if she encountered a speed-versus-quality conflict, she stated that "even if you were scheduled 8 to 4:30, you worked longer, so those were – that was kind of the big conflict there, was just you were there until it was done."

We asked another former intake worker if CSIU management gave equal emphasis to quality and efficiency. "I would say it really just depended on what was going on," she replied. "There were sometimes where quality was leaned on, and there's sometimes that quantity was leaned on."

We believe it was not a coincidence that the only intake we reviewed which met the policy expectation to include any relevant history from prior child abuse reports was handled on an after-hours basis by a veteran employee with significant experience in both the intake and assessment sides; and who also had significantly more time than is typically afforded to intake workers at CSIU.

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Despite efforts to slow the pace with a new approach to queue management, we heard from intake workers that the pressure has not dropped. “We’re being pushed faster now than ever before,” one intake worker told us. She later added, “They just keep pushing it faster and faster. We just say, ‘We’re not robots,’ you know. They just press the machine faster.”

Balancing these two opposing objectives – speed versus quality – is an ongoing challenge for CSIU’s intake workers. Based on our review, we believe this raises legitimate concerns as to whether every child abuse report receives the level of scrutiny that is required by policy and law, particularly when the unit is operating at peak call volume. On a normal day, CSIU handles 250 phone calls and in 2018, intake workers handled an average of 155 child abuse intakes per month per intake worker.

Errors in rejected intakes not detected

If a reporter says something that is objectively important but the intake worker does not document it (or does not document it accurately), and the intake is rejected, it is unlikely that anyone will detect the error.

This is because the **reporter** has no feasible way of knowing whether their statements were accurately documented. We cannot envision any circumstances in which DHS would provide a reporter with an intake document related to a child abuse report made by that individual.²⁷³ In fact, based on our experience of interviewing reporters in the Finn case, we believe many reporters assume that everything they tell the intake worker will be accurately documented, in large part because they have no information to suggest otherwise.

It is also not likely that the **intake worker** would be aware of his or her own failure to accurately document a reporter’s statements. We found that intake workers rarely go back to listen to the audio recordings from an intake.²⁷⁴ Although SW4s review intakes and recordings monthly, they only scrutinize about one intake per month for every intake worker.

In addition, it is not likely that the **supervisor** would catch documentation errors within intake reports. We can attest from our experience during this investigation that reviewing an intake audio recording and trying to compare it to the contents of the intake document can be significantly more challenging than one might expect, depending on the length and complexity of the intake call in question. Moreover, the CSIU supervisors we interviewed told us that they do not commonly review recordings from an intake phone conversation.

Little meaningful training

When we asked CSIU officials for a copy of the unit’s policy manual, they directed us to DHS’s Employees’ Manual. During our interviews of the five intake workers, we asked how familiar they were with the referenced chapters from DHS’s Employees’ Manual. “Nobody ever told me

²⁷³ A parent who makes a child abuse report about their own child is entitled to receive a copy of any assessment report that results, but that would not include the intake report, which is a separate document.

²⁷⁴ One intake worker told us she and other intake workers never listen to the audio before finalizing an intake report, although she acknowledged that doing so could be beneficial.

Additional Concerns Identified During the Investigation

to read those,” responded one former intake worker who worked at CSIU from its inception in 2010 until early 2017.

Another former intake worker who was at CSIU from 2012 to 2017 told us that she knew the intake-related chapters in DHS’s Employees’ Manual served as CSIU’s manual. “However, I’m not sure that I’ve actually been in it for quite a bit of time,” she told us.

Noting that she began working at DHS in 2006 as a field worker, she added, “As far as the details of what the actual policy manual says, it was so long ago that I don’t recollect when I read it.”

After their first year of employment with DHS, social work staff are required by agency policy to complete 24 hours of child-welfare training annually. For fiscal year 2017 (which ended June 30, 2017), DHS reported that only 49 percent of “ongoing social work field staff” met this requirement.²⁷⁵ For the five intake workers we interviewed, their compliance with this requirement has been approximately 24 percent – substantially lower than the agency-wide figure of 49 percent. “We don’t get a lot of time for training,” one intake worker told us.

The same intake worker noted the unit’s practice of allowing no more than three intake workers to have pre-planned absences for any particular workday and added, “You can sign up for a training, and hopefully you’ll be able to go. My supervisor works very hard to do that, but we also have to – the priority is to answer that phone and have enough people there to be able to do that.”

The lack of training opportunities has “been an issue since the beginning” of CSIU, SWS Allison told us. “It absolutely is an issue.”

The intake workers also told us that although some training opportunities have been available over the years, none have involved the intake process, such as handling a difficult call or processing an intake after the call. “We would have these two-hour things that this is what you need to look for,” one former intake worker told us. She said there were no discussions where a specific intake would be analyzed along the lines of “let’s take it apart and dissect this, see what happened here and what did and did not happen so that we can make it better and see how we could have improved this. They didn’t do any of that.”

Intake unit administrator Geyer agreed:

I think we’re really good about training new workers up front about intake, all the systems. All our internal processes and all the policies and procedures, and everything like that. What I think doesn’t happen is, more advanced training on allegation writing. Just, you know, the different categories of abuse. Dive deeper into gross failure, for instance. Ones that are difficult sometimes to understand and grasp. There is just not – you can’t sign a worker up for training like that.

“One of the things that we’re trying to do next year that we put in our strategic plan is to develop some trainings for staff,” Geyer told us. He later added, “Knowing that we can’t get people out

²⁷⁵ DHS’s “Iowa Child and Family Services Review Statewide Assessment” February 15, 2018, page 101.

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to these trainings often, we need to figure out a way for the training to come to us. So that's what we're trying to work on."²⁷⁶

CHRONIC AND INHERENT CHALLENGES IN CSIU

There is a human toll for intake workers. Some of the intake workers we interviewed described feeling stressed and overwhelmed.

Six intake workers at CSIU handled an intake involving the Finn family in 2015-2016. By the end of 2017, three of those individuals had left CSIU. "I feel responsible when I'm taking an intake, this could end up like that, and I never want that again," said a former intake worker who handled one of the Finn intakes. "As an intake worker, you run that risk."

SWS Noard told us:

It is hard work, and it's sensitive information, and you can hear a lot of things that most people don't hear in a given day. And it happens day after day in a concentrated eight-hour, eight-and-a-half, nine-hour period. So, yeah, I think there's a human toll, but I don't, by any means, think that it's a place full of miserable people who wish they were elsewhere. I don't think that at all.

Secondary trauma and low morale

CSIU's Operational Manual includes a list of intake worker responsibilities. Among them, near the bottom: item number 11 states, "Thinking and acting quickly, handling crisis situations, **and coping with secondary trauma.**" (Emphasis added.)

One former intake worker explained what it is like to handle a one-hour intake call, those involving high risk situations:²⁷⁷

They're intense, very, very intense, and that's what causes the stress. They're intense for the caller. They're intense for the intake worker. They're intense for everybody because you've got such a short time limit. You've got to hurry up with that call. You've got to get as much information as you can, and you've got to hurry up so you can get all that information, get it to a supervisor so they can get it called out to the field and get that investigator out to the scene immediately.

Another former intake worker said that when the phone call has ended for a one-hour intake, "You've got a lot of anxieties, and stuff, that are built up, because of course you can't express that when you're on a call."

²⁷⁶ Geyer made these statements during our initial interview on May 23, 2018. When we re-interviewed Geyer on April 17, 2019, we asked him for an update. He said there had not been much progress, mainly due to an unanticipated vacancy in the department's training position. He added, however, that the position has been filled and the new trainer has been in contact with a CSIU supervisor. "We're kind of starting it back up," Geyer told us.

²⁷⁷ IOWA ADMIN. CODE r. 441—175.25(1)a. These are referred to as "one-hour intakes" because DHS's administrative rules state that reasonable efforts must be made to observe the child within one hour of DHS's receipt of the report when there is an immediate threat to the child's safety.

Additional Concerns Identified During the Investigation

Secondary traumatic stress has been described as a set of observable reactions to working with people who have been traumatized; the condition mirrors post-traumatic stress disorder.²⁷⁸

Symptoms include feelings of isolation, anxiety, and sleep disturbances. Left unaddressed, the symptoms can result in mental and physical health problems and poor work performance.²⁷⁹

When we asked unit administrator Geyer about secondary trauma among intake workers, he replied, “It’s a real thing for sure. I think it’s a concern of everybody.... They hear as much, if not more (than field workers) every day about how kids are hurt, or about how adults are hurt. You know, just bad stuff every day.”

One CSIU employee told us:

Secondary trauma is something that we deal with regularly.... We’re hearing things about children and vulnerable adults that are difficult to listen to. It’s difficult sometimes to ask questions about it because it’s such a sensitive situation or topic; but, you know, we do, and sometimes it’s hard not to bring it home with you.

The same CSIU employee believes the concern about secondary trauma has gone up in light of the recent increase in call volume. When asked what management has done to help intake workers, Service Area Manager Lipscomb replied, “It’s really to keep the environment as lighthearted as possible. It may seem silly to some. I think it’s helpful. I bought them a popcorn machine....”

When we asked SWS Allison about secondary trauma, he replied:

Afterwards, if it is a difficult call, you know, they have the option and opportunity to go talk to their supervisor and say, “Hey, I just had a horrible call. I need a few minutes.” ... Some people need to take a little walk. Some people need just a few minutes to decompress. I’ve had some workers, like I said, come and indicate they had a difficult call and they need time to process it. There’s also EAP (Employee Assistance Program) available.

Allison acknowledged that secondary trauma can also affect other employees, including supervisors who work closely with the intake workers. When asked how he handles secondary trauma, Allison said, “We all handle, it in different ways. I go outside, go for a quick walk, you know.”

One CSIU employee told us, “Workers really need to advocate for themselves. As a worker, I advocated for myself. If I ended up on a tough call, I would go to my supervisor and say, ‘Hey, listen, I’m a little shaken by this situation. I just need a few minutes.’”

²⁷⁸ “Secondary Traumatic Stress,” <https://www.acf.hhs.gov/trauma-toolkit/secondary-traumatic-stress>.

²⁷⁹ “Secondary Traumatic Stress,” <https://www.acf.hhs.gov/trauma-toolkit/secondary-traumatic-stress>.

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However, our interview with an intake worker included this exchange:

Ombudsman: After taking a very, very difficult call, do you have some ability to say, “Hey, boss, can I have like five minutes?” or, “Can I just hop out of intake for a little bit? I need to gather my thoughts”? Is that something that ever happens?

Intake worker: Sometimes it’s just important to do that, but we’ve never been given that permission.

One former intake worker stated:

You do feel an internal pressure to perform and continue on. They forget that you’ve just heard about a massive trauma and you’re a human too, so sometimes you do need a little bit of downtime to just kind of close it and move on to the next one, and if there was a high call volume, it just didn’t leave time to do that.

Although our interviews on secondary trauma were with intake workers, we have no doubt this also impacts field workers.

A national research study in 2019 found that 53 percent of Ohio’s child protective caseworkers have symptoms of post-traumatic stress disorder.²⁸⁰ This statistic compares with the national rate ranging from 35 percent to 75 percent of child-welfare staff.²⁸¹

A CSIU employee also told us that morale among intake workers was pretty low, with increasing workloads, and a static number of employees.

“I remember getting a call from Texas,” intake unit administrator Geyer said. “They did a research project not too long ago ... they had QI (quality improvement) people dedicated to figuring out how to stop turnover and boost morale.... [E]very state who has a centralized intake sort of has the same concerns about it and no real answers.”

SWS Allison told us that CSIU holds team meetings outside the office, where they have breakfast together and go over team meeting agendas and discuss any issues that the workers would like to talk about. He added, “We have implemented the employee-led work group where they are able to provide suggestions to leadership about improvements, things that they would like to see happen.” Geyer told us that the purpose of the employee-led work group is to engage employees in addressing any barriers to productivity or morale in the office.

CSIU management has also considered trying to bring in massage and chiropractic students to alleviate the impacts of tension and stress. “You always have what’s the budget,” Geyer said. “We can’t spend any money. But if they can come in and get some hours, it can be free, hey, you know, that could be something that would be beneficial. We’re always looking at stuff like that to try to help.”

²⁸⁰ Terry DeMio, *Soul crushing. PTSD symptoms showing up in more than half of Children’s Services workers*, Chillicothe Gazette, March 16, 2019.

²⁸¹ *Id.*

Additional Concerns Identified During the Investigation

Not enough time to take breaks

Due to the inherent stress of the intake worker job, and particularly the phenomenon of secondary trauma, one might think that intake workers routinely take advantage of their chances to take a paid break. This includes a 30-minute lunch and two 15-minute breaks each day. It is worth noting that if an intake worker skips a break, they are not allowed to “bank it” and take it later in the day.

The intake workers we interviewed, however, said that working through breaks, including lunch, is common. They use that time to process leftover intakes to avoid getting behind when the next calls come in. One worker told us she could not remember the last time she had a full lunch break. Said one former intake worker:

You were on the phone most of the time, so you couldn't get off the phone to go take your break, and when you were off the phone, you were too busy processing the intakes ... so you didn't have time to take the breaks, because if you took the breaks, it would put you further behind because when you came back from break, your phone would start ringing as soon as you came back.... You don't have time to stop and breathe, let alone stop and take a break.

“You don't have time to stop and breathe, let alone stop and take a break.”

Two staff we interviewed said that there was a unified approach to urging intake workers to take their breaks. Noard told us that there was a rotation to make sure time is afforded for people to get their breaks. He indicated that it was up to the individual to take advantage of it. Noard added:

People are wired differently, so somebody potentially is going to use their lunchtime because it doesn't feel good to them to be stacked up, so they're going to use that time to catch up and start the afternoon fresh.

I don't take a break. I don't take a lunch. I'm just working. I mean I might some days slip out of the building for a short time, but a majority of the time I'm just working in my office. I'm wired along the lines of, I don't want to get real far behind.

Similarly, SWS Allison told us, “Once or twice a week I'll take my lunch, but most of the time I just work through.”

40 minutes personal time per month

Intake unit administrator Geyer told us that management observed a wide variance in the amount of personal time used by the intake workers. “We noticed that several people had zero personal time, and then we had a few staff, probably two or three at least, that had eight to ten hours of personal time in a month,” Geyer said.

So unit management contacted other call centers to see how they handle personal time. They found a private-sector call center that allows no personal time. They also found a public-sector

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call center that allows about one minute per day of personal time. Those limits seemed “a little strict,” Geyer told us, adding that they wondered, “What would two minutes a day put us at.”

Geyer told us that unit management then talked to staff about implementing a new policy regarding personal time and that it would average about two minutes a day, or 40 minutes per month. They told staff they would still have their two breaks and lunch. The September 2017 staff meeting agenda described the change:

We know everyone needs to use the restroom or make short necessary phone calls, but the expectation is that people use their breaks or lunches as much as possible for these situations and should not be in Personal status more than 40 minutes a month.

The reaction from staff – many of whom were already commonly working through their breaks and lunches – was not positive.

“I thought it was too little,” one intake worker told us, later adding, “I don’t think it’s enough time, but then I have adjusted to that by going to the bathroom during my work time when I’m not on the phone, so that’s worked out.”

“We get two minutes to go to the bathroom for the day.”

“We get two minutes to go to the bathroom for the day,” another intake worker said.

SWS Noard emphasized that the 40-minute limit is a guideline and is not strictly enforced. He explained:

If I have an intake worker who comes into my office who says, “I just had an emergency phone call, something has happened,”... There is no part of me that’s going to say, “Okay. Go into personal status, do your business, and make sure you don’t go past two minutes.” It’s just not that way.

Decision fatigue

Decision fatigue can be explained as “the deteriorating quality of decisions an individual makes after a long period of continuous decision making. In other words, the mental work of being a ‘decider’ wears down an individual’s capacity to make sound judgments through mental exhaustion.”²⁸²

We asked a CSIU employee whether every child abuse report receives the level of scrutiny that is required by DHS policy. She replied “no” and then added:

We’re all human, and volume is high. You know, you get intake decision fatigue. There’s many different factors that go into it. So I think we all make mistakes. We miss things. Workers do, I do, supervisors do. It happens.

²⁸² Becker’s Hospital Review, *Bad choices: 13 things to know about decision fatigue*, available at <https://www.beckershospitalreview.com/hospital-management-administration/bad-choices-13-things-to-know-about-decision-fatigue.html>.

Additional Concerns Identified During the Investigation

The following exchange occurred a bit later in our interview:

Ombudsman: Would that fatigue be something experienced by mainly either Social Worker 4s and supervisors, or are you talking about the intake workers?

Employee: I would say that workers obviously have fatigue, and that's primarily because it's just back to back to back to back. Ultimately, I think that the supervisors and the Social Worker 4s, they're the ones that are ultimately responsible for making decisions, and so the intake decision fatigue sets in when you've heard, you know, 75 cases throughout the day. So with workers, they definitely get fatigue, intake fatigue. But I don't see that – they don't get as fatigued about making decisions because ultimately they know it's just a preliminary decision and a supervisor ultimately is going to make that decision. They have fatigue because they're listening to horrible things over and over and over and trying to maneuver through many different things all at once.

MANDATORY REPORTERS

Iowa is one of 18 states that require mandatory reporters to submit a written report.²⁸³ (In nine states and the District of Columbia, a written report is required only when requested by the agency that received the initial report.)²⁸⁴

Individuals in professions that have routine contact with children are required to make a child abuse report when they reasonably believe a child has been abused.²⁸⁵ These professions generally cover six fields: health, education, child care, mental health, law enforcement, and social work.

Any child abuse report by a mandatory reporter must be made both orally and in writing.²⁸⁶ To help mandatory reporters meet their legal obligation, DHS policy advises intake workers to remind mandatory reporters of their responsibility to submit a written report, and to offer to send them a copy of the form created for that purpose.²⁸⁷ (For the 10 child abuse reports received in 2015-2016 about the Finn family, we found that intake workers generally did not meet these two requirements.)

Written reports from mandatory reporters

CSIU staff does not keep track of mandatory reporters' compliance rates with the written-report requirement. According to DHS, CSIU receives about 1,700 written reports monthly from mandatory reporters, which would mean about 20,400 such reports annually.²⁸⁸

²⁸³ Child Welfare Information Gateway, *Making and Screening Reports of Child Abuse and Neglect*, available at <https://www.childwelfare.gov/pubPDFs/repproc.pdf>.

²⁸⁴ *Id.*

²⁸⁵ IOWA CODE § 232.69(1).

²⁸⁶ IOWA CODE § 232.70(1).

²⁸⁷ Both actions are required by DHS's Employees' Manual, Title 17, Chapter A(3), page 7.

²⁸⁸ DHS's unsigned November 2, 2017, letter of response.

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All 10 of the child abuse reports received by DHS about the Finn children in 2015-2016 were made by mandatory reporters. Only four of those 10 mandatory reporters submitted the required written report.

Of the four written reports submitted by the mandatory reporters in the Finn case, we found that two of those reports repeated information that the reporter had already discussed during the intake phone conversation, but that the intake worker had not documented. Even though that information was presented to DHS a second time through the written report, we found no indication that the information was documented anywhere by DHS.

We learned from our interviews of CSIU management that prior to Natalie's death, nobody in the unit was designated to review written reports received from mandatory reporters regarding rejected intakes. Our interview of unit administrator Geyer included this exchange regarding why nobody was designated to review those written reports:

We learned from our interviews of CSIU management that prior to Natalie's death, nobody in the unit was designated to review written reports received from mandatory reporters regarding rejected intakes.

Ombudsman: I gotta ask, why would that be? I mean, here a reporter actually did do what she was required by the law to do.

Geyer: Right.

Ombudsman: She not only once on a phone call, but then a second time submitted some important information about a child abuse allegation.

Geyer: Right.

Ombudsman: And it didn't get documented either time.

Geyer: Right. Well, I'm not sure of the answer why it wasn't. I mean, that's just never been the practice since forever. I mean, we have started doing that.

Following DHS's internal investigation of the Finn case, CSIU implemented a new practice whereby the two SW4s are assigned to review written reports from mandatory reporters for rejected intakes. Since written reports submitted by mandatory reporters for rejected intakes had typically not been reviewed, it is unlikely that anyone reviewed the statutorily required written reports submitted by the mandatory reporters for the May 27 and October 5 intakes – or any other written report from a mandatory reporter for a rejected intake before 2017.

According to intake unit administrator Geyer, since the above-mentioned change in practice, thousands of written reports from mandatory reporters have been reviewed. Out of those reviews, he said the information in the written reports has caused a flip – changing the intake decision from reject to accept – 1 to 2 percent of the time. “If they call us and they submit a report,” Geyer added, “they typically write much less because they know they talked to us.”

Geyer's comments suggest CSIU staff is spending a lot of time reading reports from mandatory reporters that are meaningful less than 2 percent of the time.

Additional Concerns Identified During the Investigation

Greater weight was not given to mandatory reporters

DHS's internal investigation addressed the importance of calls from mandatory reporters:

This case highlights the need to think differently about reports from mandatory reporters.... (T)he department should take into consideration if a mandatory reporter has a level of expertise based on specialized training in the matter being reported, such as the school nurse reporting a concern of malnourishment. In those situations, we will give more weight to what the mandatory reporter is reporting.²⁸⁹

We believe there is merit in giving more weight to reports from mandatory reporters, due to their specialized training. However, a current CSIU intake worker and a former intake worker told us that they did not recall ever being advised to give greater weight to reports from mandatory reporters. "I don't remember any discussions or meetings about mandatory reporters specifically," the intake worker told us, later adding, "I don't remember that coming up in a meeting, or anything."

DHS's QUALITY ASSURANCE PROGRAM

Our office's investigation into the tragic death of Shelby Duis resulted in findings on both the intake side and the assessment side of DHS's child welfare system. One of our recommendations in 2000 stated:

DHS [should] increase the frequency and depth of supervisory and program staff review of completed intakes and assessments, and encourage consultation with supervisory and program staff; ... DHS [should] evaluate whether it has staffing resources necessary to provide adequate review, oversight, and consultation, and if such resources are inadequate, make any required personnel and budgetary requests to the Governor and the General Assembly.

In response to that recommendation, then-DHS Director Jesse Rasmussen wrote:

- We have initiated discussions within DHS to identify ways to improve our current monitoring and review process with the intent of revising current processes by June 2001.
- In addition, the Council on Human Services Fiscal Year 2002 budget request has included funds **to create a quality assurance team for child protective services**. (Emphasis added.)

Several years later, DHS's Quality Assurance (QA) program played a key role in a 2006 systemic review of both the intake and assessment sides of DHS's child welfare program. An overview document, titled "CPS System Review State Summary" stated:

²⁸⁹ DHS's Executive Summary, page 11.

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This statewide review focused on the role of intake and assessment in the life of the case, with the goal of assessing current performance and facilitating improved practice throughout the Child Protective Services system....

(B)ecause the reviews took a proactive approach, they were very strength-based and involved collaboration through the interview process between the reviewers and the staff directly involved in the case.

According to the summary, one of the concerns identified involved failures to gather and document critical information, including the identity of collateral witnesses.

Our review indicated that the 2006 CPS System Review appeared to be a significant undertaking with wide-reaching impacts on both intake staff and assessment staff in the field. Over the next decade, however, DHS did not undertake any other systemic reviews of the child abuse intake process. The next such review was in 2017, after the death of Natalie and seven years after CSIU's establishment.²⁹⁰

We asked DHS to identify any improvements to CSIU's intake process and/or the after-hours intake process undertaken as a direct result of DHS's QA program since the establishment of CSIU in 2010. DHS responded with a list that showed one improvement in 2010 – "Lean Design Event, design of centralized intake" – but nothing else for the next five years.

DHS's list included two improvements in 2015, neither of which directly involved the child abuse intake process:

- Implemented [a] plan for review of information and referral calls to assist with ensuring allegations of abuse are not missed.
- Developed and implemented emergency plans for assisting callers when CSIU loses internet connection and/or phone access.

DHS identified one such improvement undertaken in 2016: "Developed process map for revised urgent reject process that informed future system change."

In summary, when Natalie died, CSIU had been operating for six years. During that six-year period, the intake process at CSIU had benefited from just two improvements that were attributed to DHS's QA program: It helped to design the centralized intake process in 2010, and it developed a process map for revised urgent reject practices.

²⁹⁰ In June 2014, DHS submitted a 191-page report, *Title IV-B Child and Family Services Plan, FFY 2010-2014 Final Report*, to the federal Children's Bureau of the United States Department of Health and Human Services' Administration for Children and Families. The report stated that DHS's QA programs focused on ensuring the quality and effectiveness of services to children and families by "establishing desired outcomes and standards of expected performance," which relied primarily on CFSR standards and DHS's Child Welfare Model of Practice. Further information on CFSR standards can be found at https://www.acf.hhs.gov/sites/default/files/cb/cfsr_general_factsheet.pdf.

Additional Concerns Identified During the Investigation

In the two years following Natalie's death, there were nine such improvements listed, although we believe a few are debatable as to whether they are bona-fide "quality assurance" improvements.

Overall, the main purpose of the Ombudsman's 2000 recommendation for the creation of a centralized intake unit was to improve intake-process quality. Although clearly there has been improvement in that quality from then to now, we believe CSIU would have benefited even more had it been included more often in the QA program's efforts. Instead, it appears the main purpose of the QA program was to assist DHS in complying with the federal performance measures, none of which explicitly mention the intake process.

CONCLUSIONS AND RECOMMENDATIONS

According to DHS officials, our review was the first independent investigation of CSIU's intake process since the unit's inception in 2010. We found that child abuse call volumes and accepted intakes have increased significantly since Natalie's death. This has resulted in significant increases to field workers' average caseloads. Fortunately, additional funding for field staff was approved in 2019.

However, the increased number of child abuse calls is also straining CSIU. The number of intake workers has not increased; hold times for reporters of child abuse are increasing; there is significant tension at CSIU between the dual expectations of speed and quality; and staff are not getting the training they need.

CSIU's Strategic Plan for 2018-2019 also identified a number of the same "weaknesses" we found, including:

- Few opportunities for additional training for staff and supervisors
- High call volume with minimal staff
- System issues
- Staff shortages
- Lack of ability to maintain licensure/training²⁹¹

Our investigation of the Finn case found that a shortage of staff – and therefore a lack of time – has adversely impacted CSIU's ability to give every intake the quality treatment it deserves.

Staff are tasked with unrealistic expectations and requirements. Intake staff are expected to accurately document what reporters say and to review prior child abuse reports even though they have limited time to do so. We found several intakes in the Finn case that were inaccurate and/or incomplete. With one exception, intake staff did not have time to review the prior reports about

²⁹¹ DHS, *Centralized SA CY 2018-2019 Unit Strategic Plan*. The same document also identifies several "strengths," including:

- Experienced workers with lots of knowledge.
- Quality intakes are taken.
- Dedicated workers.
- Supervisors and administration are supportive.

Ombudsman Investigative Report

Natalie and her siblings. The only intake that met the policy expectation to include a summary of relevant history from prior reports was handled by an after-hours worker; she had more time than is typically afforded to an intake worker at CSIU.

The obvious resolution to address these problems would appear to be to hire more staff and create additional efficiencies.

The obvious resolution to address these problems would appear to be to hire more staff and create additional efficiencies.

Many states have implemented online options for reporting child abuse if a child is not in immediate danger. Some states restrict online reporting to only mandatory reporters. The benefit of online reporting is two-fold: accuracy of documenting the information from the reporter and it would reduce CSIU's call volumes (and wait times).

And then there is the human toll. CSIU intake workers and field workers are subject to secondary trauma. CSIU workers do not routinely take full advantage of regularly scheduled breaks and are limited to 40 minutes of personal time per month. Supervisors are exposed to decision fatigue and yet they also do not take full advantage of breaks. These challenges are exacerbated any time too many staff are absent or when there is turnover.

During our site visit and interviews, we found the staff to be dedicated professionals with a strong work ethic rooted in a desire to serve victims of abuse and their families.

Our investigation included a visit to CSIU on a weekday morning. During our site visit and interviews, we found the staff to be dedicated professionals with a strong work ethic rooted in a desire to serve victims of abuse and their families. "I know that everyone at intake, their heart is truly in there for the protection of children or they wouldn't be there," one former intake worker told us. "And they feel awful when something falls through the cracks."

We believe another tragedy could happen if DHS field and intake workers are not given the resources and support they need and deserve.

The Ombudsman recommends that DHS:

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 requirement 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 the 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.

Additional Concerns Identified During the Investigation

- 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.**

- 12. Create an online child abuse reporting system for child abuse reports where there is no immediate danger to the child.**

- 13. Modify policy and training to instruct CSIU intake staff to consider giving more weight to child abuse reports made by mandatory reporters.**

- 14. Provide training and resources for intake and field staff impacted by secondary trauma, decision fatigue, and other job-related stress.**

Appendix A: Motion to Compel

16-2613

IN THE DISTRICT COURT FOR POLK COUNTY, IOWA

IN THE INTEREST OF



CHILDREN

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JV M013

**MOTION TO COMPEL INTERVIEW
OF A CHILD PURSUANT TO IOWA
CODE SECTION 232.71B(5)**

COMES NOW the State of Iowa, by and through the undersigned attorney, and states the following to the court:

1. Pursuant to Iowa Code Section 232.71B *Duties of the department upon receipt of report* the Department "may, with the consent of the parent or guardian, include a visit to the home of the child named in the report and an interview or observation of the child may be conducted. If permission to enter the home or interview or observe the child is refused, the juvenile court or district court upon a showing of probable cause may authorize the person making the assessment to enter the home and interview or observe the child."
2. On or about May 31, 2016 an anonymous caller reported concerns that the above children do not receive enough food. There have been three rejected intakes in 2016 stating the children are not fed enough.
3. On or about June 2, 2016, DHS opened a child abuse investigation after it received the allegations.
4. It is reported that all four children live with their mother.
5. All four children are reportedly adopted and the mother receives subsidy. Information received from the Reporting Party indicates two of the children that were seen on or about May 31, 2016 appear unkempt wearing dirty clothing. They appeared in such poor

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POLK COUNTY, IOWA
2016 AUG 10 AM 8:19
CLERK DISTRICT COURT

16-2613

- condition that bystanders at a gas station where two of the children were reportedly asking for food called the police believing the children to be in desperate need.
6. On the same date, a second call came into police stating Natalie did not have enough food was being locked in her room. Police responded to the family home, but no one would come to the door.
 7. Previous reports indicate the mother may be running an animal shelter from the home. DHS reports Animal Control was also unable to get anyone to come to the door.
 8. DHS reports they have attempted to contact the mother, Nicole Finn, multiple times, including: going to the home on 6/1/16, 6/7/16, 6/13/16, and 7/5/16. DHS also sent a letter to the home on 6/13/2016, sent a request for the mother to meet with the County Attorney's Office on 8/2/16, and sent an email on 7/26/16.
 9. During one visit to the home DHS reports the windows of the home being covered up. DHS reports the family vehicle has been in the driveway when they have attempted contact, and yet no one will answer the door.
 10. DHS reports the last contact with the mother was via email on June 14, 2016 in which the mother indicated she would be calling the DHS worker and indicated her willingness to comply. DHS has since been unsuccessful in communicating with the mother or ensuring safety of the children. The mother has refused to meet with DHS, and therefore DHS is unable to ensure the children's safety.
 11. Given the allegations and non-compliance by the mother, the State believes there is sufficient evidence of probable cause to support the Court ordering DHS to interview and observe the children in order to assess their safety and well-being.

Appendix A: Motion to Compel

16-203

WHEREFORE, the State motions the Juvenile Court to find that probable cause exists to authorize DHS to interview the child.

Respectfully submitted,

JOHN P. SARCONI
Polk County Attorney

/s/ Jesse Ramirez
JESSE RAMIREZ
Polk County Attorney's Office
222 Fifth Avenue
Des Moines, IA 50309
(515) 286-3024
Jesse.Ramirez@polkcountyiowa.gov

Appendix B: Order to Compel

IN THE DISTRICT COURT FOR POLK COUNTY, IOWA

IN THE INTEREST OF



A CHILD

*
*
*
*

JV MO131

ORDER TO COMPEL INTERVIEW
OF A CHILD PURSUANT TO IOWA
CODE SECTION 232.71B(5)

Now on this 9th day of AUGUST, 2016, this matter comes to the attention of the Court by the motion of the State. The Court, being fully advised in the premises and based on said motion, FINDS, that probable cause does/~~does not~~ exist to grant the motion to compel the interview of the above named children filed by the State. IT IS THEREFORE THE ORDER OF THE COURT THAT the above named children shall/~~shall not be~~ interviewed by DHS. All parties entitled to notice shall be mailed a copy of this Order by regular U.S. mail.

** and DHS is authorized to enter
the home to interview or observe the children
JWS*

JUDGE FOR JUVENILE COURT

Original filed.
DHS to provide copies to mother.

FILED
POLK COUNTY, IA.
2016 AUG 10 AM 8:42
CLERK DISTRICT COURT

Appendix B: Order to Compel

WHEREFORE, the State motions the Juvenile Court to find that probable cause exists to authorize DHS to interview the child.

Respectfully submitted,

JOHN P. SARCONI
Polk County Attorney

/s/ Jesse Ramirez
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Appendix C: Child abuse report statistics 2000-2018

Year	Child abuse reports received	Reports rejected (percentage of reports received)	Reports accepted for assessment (percentage of reports received)	Assessments resulting in a confirmed or founded conclusion (percentage of reports received)
2000	33,193	11,917 (35.90%)	21,276 (64.10%)	NA
2001	37,507	12,395 (33.05%)	25,112 (66.95%)	NA
2002	35,612	12,397 (34.81%)	23,215 (65.19%)	NA
2003	36,823	12,651 (34.36%)	24,172 (65.64%)	NA
2004	38,040	12,770 (33.57%)	25,270 (66.43%)	9,690 (25.47%)
2005	39,752	14,163 (35.63%)	25,589 (64.37%)	9,384 (23.61%)
2006	42,457	17,509 (41.24%)	24,948 (58.76%)	9,779 (23.03%)
2007	39,847	16,049 (40.28%)	23,798 (59.72%)	9,086 (22.80%)
2008	40,237	17,001 (42.25%)	23,236 (57.75%)	7,981 (19.83%)
2009	42,517	16,703 (39.29%)	25,814 (60.71%)	8,867 (20.86%)
2010	43,025	16,612 (38.61%)	26,413 (61.39%)	8,981 (20.88%)
2011	49,355	18,608 (37.70%)	30,747 (62.30%)	9,712 (19.68%)
2012	52,964	24,046 (45.40%)	28,918 (54.60%)	9,616 (18.16%)
2013	48,621	22,492 (46.26%)	26,129 (53.74%)	8,911 (18.33%)
2014	48,152	24,590 (51.07%)	23,562 (48.93%)	5,534 (11.49%)
2015	47,499	23,201 (48.85%)	24,298 (51.15%)	6,042 (12.72%)
2016	49,066	23,359 (47.61%)	25,707 (52.39%)	6,484 (13.21%)
2017	54,362	20,944 (38.53%)	33,418 (61.47%)	8,558 (15.74%)
2018	56,552	21,523 (38.06%)	35,029 (61.94%)	8,743 (15.46%)

DHS's Reply



Kim Reynolds, Governor

Adam Gregg, Lt. Governor

Kelly Garcia, Director

Office of the Ombudsman Investigative Report: DHS Response

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 as appropriate and required by law and values this partnership. In this response, DHS will address each of the Ombudsman's recommendations.

Findings

The Ombudsman report acknowledges a number of positive steps taken by DHS following our internal review and the independent external review, conducted by the Child Welfare Policy and Practice Group (CWPPG), as requested by DHS in 2017, such as:

- Intake staff consistently review accept/reject history and corresponding themes to inform intake decisions.
- Pertinent information on perpetrators, all family members, previous allegations, and previous assessment findings are more readily available to intake staff.
- When staff go on leave and safety has not been assured, the case needs to be reassigned to a different worker.
- The information system now auto-fills prior history into the intake document, which includes the allegation, if it was founded, confirmed, or not confirmed.
- Intake supervisors are now focusing more on cases where the intake worker is making a preliminary decision to reject a report.
- Intake no longer rejects intake information to an open addendum. The process of an intake decision is no longer affected by whether there is an open case or open addendum. Intake no longer assigns new information to an open case. The decision to accept or reject will be made, and all accepted cases are opened for assessment without regard to current open cases.
- New allegations accepted at intake on current assessments will be "linked" to and auto-populate into the current open assessment, and include new observation timeframes.
- Supervisors complete a more in-depth review of case history.
- If a staff or supervisor requests a motion to compel, they must review it with a Social Work Administrator and the motion should be requested from the County Attorney's office within the first 20 days of an assessment.
- Addendums will be open no more than 20 days and only for reasons stated in policy.]

Recommendations

In addition to the steps already taken or in process by DHS, the Ombudsman's Report identified 14 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 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.*

Response: 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 they was no subsequent abuse within that five year period.

- 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.*
- 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.*
- 4) *Continue monitoring rates by which intake workers collect information on collaterals and continue stressing the importance of collecting that information.*
- 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.*
- 6) *Continue to monitor and solicit feedback from intake workers for any concerns about conducting system checks.*
- 7) *Update its Employees' Manual to explicitly require intake workers to review all prior intakes and assessments, not just rejected intakes.*

Response (2-7): The Department agrees with all of these recommendations. As a matter of best practice, we summarize the reported concerns and review those with the reporter. While we do not read our full written narrative back to the caller, we provide the reporter an opportunity to say 'you didn't hear me.'

DHS's Reply

This case has also changed the way our workers approach allegations of less common forms of abuse. Now workers probe with better questions at a secondary layer. For example, when there are reports of malnutrition workers probe whether food is being withheld as punishment and if isolation is a component of the allegation. We use this deeper probing technique regardless of the nature of the allegation.

- 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.*

Response: The Department agrees with this recommendation.

- 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 not 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.*

Response: The Department agrees with this recommendation. The partnership with law enforcement is incredibly important and requires balanced collaboration.

We will work with our legal team to develop training on orders to compel and will establish it as part of the core training curriculum. We will explore best practices, identify what good casework looks like in relation to an order to compel and establish a legal framework to inform our curriculum.

- 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.*

Response: The Department agrees with this recommendation. We have implemented related changes, provided training and updates to the manual are in process to support these changes.

- 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.*

Response: The Department agrees with this recommendation.

- 12) *Create an online child abuse reporting system for child abuse reports where there is no immediate danger to the child.*

Response: The Department agrees that it's critical to ensure that the process for reporting abuse is convenient and accessible to reporters. DHS is exploring ways to provide additional options for reporting abuse 24/7.

- 13) *Modify policy and training to instruct CSIU intake staff to consider giving more weight to child abuse reports made by mandatory reporters.*

Response: The Department does not agree with this recommendation. This case highlighted a need to think differently about reports from mandatory reporters. The law requires that we consider how a reporter knows of the concerns being reported. Often mandatory reporters have first-hand knowledge or expertise based on direct interactions with the children. In those situations, we should give more weight to what the reporter is telling us as we make our decision. However, often times a neighbor may have far more information on family and community dynamics. They notice changes in appearance and behavior, may hear fighting and have significantly more detail to provide.

- 14) *Provide training and resources for intake and field staff impacted by secondary trauma, decision fatigue, and other job related stress.*

Response: The Department agrees with this recommendation. This recommendation is critical. We have a moral obligation to provide for the well-being of our team members. There is a clear gap in addressing the secondary trauma experienced by DHS staff. We need an approach that wraps around our workers and provides cohesive support.

The needs of our staff are significantly more complex than other state employees. We need explore ways to address the broader needs of our team members. We need to explore meaningful ways to support them, to address decision fatigue, to identify best practices and replicate them around the state.

This includes developing ways to provide coordinated trauma response for workers and supervisors throughout the life of a case, trial and after. This system-wide informed trauma response needs to be embedded in the culture at DHS. This should be a holistic approach across the agency, not just for those who work in child welfare.

DHS's Reply

The Department is exploring efforts to create a work environment that provides support to address secondary trauma experienced by our team members, which may include:

- Converting break rooms into lounges with couches, chairs, rugs, magazines and televisions to create more of a home-like feel.
- Painting and adding art and decorations around the office to make it feel less like a 'government' office.
- Allowing therapy dogs into the office similar to the approaches used by our community partners, hospitals and other facilities.
- Combining lunches and breaks, at least occasionally, so people can go out to lunch together. This presents some logistical challenges in a call center, however we can explore options to address this concern.
- Creating wellness spaces, which may include an exercise rooms and equipment.
- Mandating breaks as many choose not to take them.

The Department will be engaging with our community partners who have successfully implemented similar approaches. These ideas may change or expand as discussions progress and we move forward.

Conclusion

Our team is dedicated and committed to the families we serve. This was a tragic case. The Finn children should never have had to endure the treatment they received. All of us at DHS were deeply impacted by the loss of Natalie and the trauma to her siblings. We will learn from this and improve the safety net DHS provides to Iowa's children. Some of the work to improve the Department's response began immediately, but a large part of the Department's ongoing efforts will focus on finding better ways to support our team so they can better support the families we serve.

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.

The Department is grateful to the Ombudsman for their insightful recommendations and looks forward to working together to ensure the safety of all of Iowa's children.

Ombudsman's Comments

This was a tragic case. The Finn children should never have had to endure the treatment they received.

DHS'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 and twelve current and former DHS employees were offered the opportunity to reply to the report. The Ombudsman received only one written reply to this report: from DHS Director Kelly Garcia, beginning on page 152.

As acknowledged in our report, DHS officials have implemented a number of positive changes since Natalie's death to address problems related to this case. In addition, DHS affirmatively accepted 11 of my 14 recommendations. This includes my recommendations for DHS to:

- Conduct a systemic review of CSIU operations, including the adequacy of CSIU staffing levels.
- Provide training and resources for intake and field staff impacted by secondary trauma, decision fatigue, and other job-related stress.
- Provide training and written guidance on legal tools available to field workers when faced with resistance from parents. This includes in-depth training on orders to compel – what they are, when to consider pursuing one and how to execute it.

I would, however, like to comment on several of DHS's responses to my recommendations:

- ***Ombudsman's recommendation:***
 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

Ombudsman's Comments

during that timeframe, DHS shall retain these abuse assessments for an additional 10 years.

- c. Indefinitely for “founded” child abuse assessments.

DHS's response:

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 not subsequent abuse within that five-year period.

Ombudsman comment:

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.

- ***Ombudsman's recommendation:***

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.

DHS's response:

As a matter of best practice, we summarize the reported concerns and review those with the reporter. While we do not read our full written narrative back to the caller, we provide the reporter an opportunity to say ‘you didn't hear me.’

Ombudsman's comment:

We listened to the audio recordings of six intakes in this case. We did not hear intake workers summarize the reported concerns and review those with the reporters.

We will conduct random reviews of intake calls in the future to confirm this practice is taking place and to determine whether it sufficiently addresses our concerns regarding inaccurate and incomplete documentation of child abuse reports.

- ***Ombudsman's recommendation:***

12. Create an online child abuse reporting system for child abuse reports where there is no immediate danger to the child.

DHS's response:

The Department agrees that it's critical to ensure that the process for reporting abuse is convenient and accessible to reporters. DHS is exploring ways to provide additional options for reporting abuse 24/7.

Ombudsman's comment:

I will continue to monitor DHS's efforts to provide additional options for reporting abuse.

- ***Ombudsman's recommendation:***

13. Modify policy and training to instruct CSIU intake staff to consider giving more weight to child abuse reports made by mandatory reporters.

DHS's response:

The Department does not agree with this recommendation. This case highlighted a need to think differently about reports from mandatory reporters. The law requires that we consider how a reporter knows of the concerns being reported. Often mandatory reporters have first-hand knowledge or expertise based on direct interactions with the children. In those situations, we should give more weight to what the reporter is telling us as we make our decision. However, often times a neighbor may have far more information on family and community dynamics. They notice changes in appearance and behavior, may hear fighting and have significantly more detail to provide.

Ombudsman's comment:

Point taken but we are not suggesting that reports from non-mandatory reporters should not be given serious consideration. DHS's response omits the fact that mandatory reporters are trained with a curriculum approved by DHS. According to DHS's July 2019 publication, *Child Abuse: A Guide for Mandatory Reporters*, mandatory reporters are required by law to "make a report of child abuse within 24 hours when they reasonably believe a child has suffered abuse." The 84-page publication provides guidance for

Ombudsman's Comments

mandatory reporters and identifies them as “professionals who have frequent contact with children” generally in the professions of health, mental health, education, law enforcement, child care and social work.”

Mandatory reporters – mainly professionals – are trained on an on-going basis and required to identify and report abuse. In light of this, my recommendation stands.

In closing, I would like to again thank Director Garcia and her staff for their cooperation.