

**Investigative Report
00-2**



**Investigation of the Department of Human Services' handling of allegations of
child abuse concerning Shelby Duis**

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and

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and

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RE: Case File 00-565

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Table of Contents

Ombudsman's Report

Executive Summary	i - viii
Overview	1
Department of Human Services Role and Organization	9
Reporting Process	11
Intake Process	16
Assessment Process	21
Chronology of Events and Ombudsman's Findings	33
Medical and Child Abuse Consultant	84
Analysis and Conclusions	90
Recommendations	122
Appendix	

Reply by Jessie Rasmussen, Director, Department of Human Services

Reply by Charles Illg, Child Protection Worker, Department of Human Services

Executive Summary

Role of the Ombudsman

The Citizens' Aide/Ombudsman is an independent, nonpartisan, impartial agency of the Iowa Legislature. The Ombudsman is responsible to receive and investigate the administrative actions of most Iowa state and local governmental agencies. The Ombudsman's powers and duties are defined in Iowa Code Chapter 2C.

The Ombudsman may conduct an investigation based on a complaint or on the Ombudsman's own motion. The Ombudsman is responsible for investigating agency actions that may be contrary to law, regulation, or policy, or that may be unreasonable, unfair, oppressive, inconsistent, mistaken, arbitrary, improper, irrelevant, or otherwise objectionable. The Ombudsman may also review agency procedures and practices and recommend how to strengthen or improve them.

After completion of an investigation, the Ombudsman may issue a report of the Ombudsman's findings, conclusions, and recommendations.

Shelby Duis Investigation

At the request of three members of the Iowa Senate, the Ombudsman undertook an investigation into the policies and practices of the Iowa Department of Human Services (DHS) in the handling of child abuse allegations regarding Shelby Duis. The Ombudsman issued notice of the investigation on February 10, 2000, approximately five weeks after Shelby died.

In conducting the investigation, the Ombudsman researched Iowa law and DHS regulations (administrative rules), examined DHS policy and procedures, interviewed and took sworn testimony from DHS staff and other witnesses, reviewed relevant documents, reports, and trial testimony, made inquiries to several other states regarding their system for receiving child abuse reports, and consulted with a child abuse medical expert.

Findings and Conclusions

Given the Ombudsman's statutory role and responsibility and the extensive review involved in the investigation, this report focuses on those policies, procedures, or practices the Ombudsman found to be questionable or inappropriate, and could be improved or strengthened. It should be noted the Ombudsman found many actions or decisions by DHS workers to be appropriate. There were also some actions or decisions about which the Ombudsman could not make any findings or reach any conclusions, given the evidence that was obtained or was available.

The Ombudsman found a number of instances when DHS staff did not respond appropriately or could have responded differently to concerns raised about Shelby. These instances relate to the way reports and intakes were handled and the way assessments were completed. However, the Ombudsman did not draw any conclusions whether and to what extent Shelby could have been protected from the abuse that ended her life.

The Ombudsman believes many of these instances are indicative of the need for certain policy and practice changes or improvements within DHS and in the way DHS interacts with components of the child protection system in Iowa. They may also be indicative of larger, more system-wide problems within Iowa's child protection system.

While many of the problems identified in this report can be characterized as practice problems and addressed by training and supervision, the Ombudsman believes those problems can also be reduced by modifications or clarifications of policy and by a systemic change to the reporting and intake process. Streamlining how reporters interact with the DHS child abuse system and dedicating a centralized unit of uniformly trained intake workers would go a long way toward resolving individual differences and regional variances found in the current decentralized intake system. It could ensure consistent, accurate, and appropriate responses to the initial reports of child abuse or neglect. Structural reorganization coupled with certain policy changes could reduce the instances of policy and practice shortcomings identified in this investigation.

Reporting Process Problems

The Ombudsman reviewed the process reporters go through in making child abuse reports to DHS. Challenges during the process include ensuring reporters can quickly and effortlessly communicate with DHS employees who are responsible for gathering report information and making decisions whether to accept, reject, or refer the report for services.

With respect to Shelby's case, the Ombudsman found:

- In one instance, DHS identified the “reporter” of child abuse as the person who relayed the allegation of abuse to DHS. The person who initially made the allegation and had first-hand information about the abuse was not considered the reporter. There were two other instances involving relayed reports in which it was not clear to the Ombudsman whom DHS considered to be the reporter.
- In one instance, a mandatory reporter did not make a report of suspected abuse to DHS; and as a result DHS did not have knowledge of important information concerning Shelby's care and condition.
- In four instances, mandatory reporters who made oral reports of abuse did not follow-up with written reports, as required by Iowa law.
- In two instances, DHS employees, who were not intake workers, considered calls from persons who suspected abuse as calls “expressing concerns” only, not as calls “reporting

abuse.” As a result, neither call was referred to an intake worker for an intake decision. [DHS has since issued a written clarification to all employees that any information that raises concerns about the care of a child is to be referred immediately to the appropriate child protection staff as a report of child abuse.]

- In two instances, intake workers did not promptly return calls from persons whom they knew wanted to make reports of child abuse.
- In several instances, reporters had difficulty reaching intake workers. Most of the time their difficulty stemmed from not understanding how the reporting system works, especially since it varies depending on where and when the call is made and where the child lives. When calling the local DHS office, reporters often had to leave messages with clerical staff and await return calls. Some reporters believed they had to call the same intake worker every time and, if the worker was not available, leave messages on the worker’s voice mail. Most reporters had to talk with more than one DHS employee before making contact with an intake worker.
- A document containing critical information regarding a report of child abuse, completed by a DHS employee taking after-hours calls to the child abuse hotline, was not provided to the intake worker, nor included in the official intake record. [DHS has since addressed this problem by providing written report information from the hotline to intake workers.]

Intake Process Problems

A reoccurring problem discovered by the Ombudsman was that intake workers did not always document every contact concerning a child as an intake (e.g., if they did not consider the caller’s information to be an allegation of abuse). [Again, DHS has since issued a written clarification that any information that raises concerns about the care of a child shall be treated as a report of child abuse.]

The Ombudsman also identified problems related to insufficient documentation of intake information, inappropriate decisions to reject reports, and inconsistencies with intake decisions. It is noteworthy that a consultant’s report produced for the Ombudsman in early 1999 found wide variation around the state regarding the “thoroughness of case record rejection verification.” The same consultant’s report noted the level of actual supervisory oversight and involvement was unclear. Policy clarification, along with additional training and supervisory guidance, may help to address these problems. The Ombudsman believes these problems can be reduced by having a centralized unit of specially trained workers whose primary responsibility is to receive and document reports and to make intake decisions.

With respect to Shelby’s case, the Ombudsman found:

- Two reports of child abuse were not handled and documented as intakes.

- In each of three instances involving alleged physical abuse, the intake information did not sufficiently describe the reported injuries.
- Three reports of child abuse that were rejected should have been accepted for investigation or assessment. The last rejected report occurred three weeks before Shelby died.
- One report of child abuse should not have been rejected without first conducting an in-depth intake (i.e., contacting mandatory reporters who may have relevant information).

Assessment Process Problems

The Ombudsman identified a number of policy and practice problems concerning how the investigations and assessments concerning Shelby were conducted and documented. The majority were practice issues – actions the Ombudsman believes the Child Protection Worker (CPW) reasonably should have taken under DHS policy. Additional training and supervisory consultation and review may help to ensure that CPWs identify and interview all relevant witnesses and collateral sources to ensure a thorough understanding of the situation and development of the relevant facts, including verification of the explanation or history given for an injury. Training and supervision are also important components to assist CPWs in identifying signs of abuse (including the appearances and patterns of injuries, and the mechanisms for injuries), and in developing their assessment skills (including photographic documentation, use of measurement tools, and other investigative means to gather information).

Other problems with certain assessment actions may require policy promulgation, modification or clarification. For example, the Ombudsman believes a CPW should be required to attempt to contact the doctor before an examination and share information about the alleged abuse and the explanation given for the injury or condition. Policy should be clarified to assure that service referrals are acted upon and in a timely manner.

With respect to Shelby’s case, the Ombudsman found:

- In several instances, the CPW did not contact and interview persons who may have had relevant information regarding the allegations of abuse. In other instances the CPW did not observe, inspect, collect or consider evidence to the fullest extent possible.
- In several instances, the CPW noted concerns about the caretaker’s behavior, but did not specify the nature of those concerns nor follow up on verifying or assessing those concerns.
- Three weeks before Shelby’s death, the CPW received additional information about Shelby while an assessment was still open and had sufficient concerns to repeatedly refer Shelby to a doctor, but did not take any further assessment actions, including observation of Shelby, to ensure that she was not being abused and was safe.

Recommendations

The Ombudsman recommends:

1. The Department of Human Services (DHS) redesign the child abuse reporting system so that:
 - a. Reporters have a single point of contact which they can be instructed to call, regardless of where they live, the time of day, or the county, cluster or region having responsibility to evaluate the report.
 - b. Reporters are able to speak with an intake worker during their initial call.
 - c. All report information, regardless of who initially receives the report, be promptly documented and retained, timely routed, and appropriately evaluated.

[The Ombudsman believes DHS would gain valuable insight, perspective, and assistance in responding to this recommendation by consulting with appropriate social service staff in states that have a state-wide centralized child abuse hotline system for reports and intakes (such as Arizona, Florida, and Texas), regarding their rationale for and experience in implementation of such a system.]

2. DHS review its definition of who is a “reporter,” and, if possible without statutory change, modify it to also include an individual who has been identified by a reporter (i.e. person calling DHS) as the source of the allegation and as the individual wanting to make a report of child abuse.
3. DHS increase efforts to instruct and remind mandatory reporters about the importance and need to report suspected abuse directly to DHS.
4. DHS increase emphasis on training, encouraging, and reminding mandatory reporters to file written reports and should consider ways to facilitate the filing of written reports.
5. DHS review the 48-hour time frame for filing of written reports by mandatory reporters and determine if it should be enforced and/or extended.
6. DHS modify policy to clearly provide that written reports that are received will be reviewed before a final decision or approval is made to reject the report. In the event a written report is received after a rejection decision is made, a supervisor should review and determine if the rejection decision should be reconsidered.
7. DHS provide public education and awareness to increase reporters’ and the community’s understanding of DHS’s role and how the child protection system functions, including the responsibilities and limitations of the various DHS workers.

8. DHS monitor and ensure compliance by employees with the September 18, 2000 policy directive that “information that raises concerns about the care of a child” be relayed to the “child protection unit” and treated as a report of child abuse.
9. DHS adopt a policy providing that intake workers (those responsible for gathering report information and making intake decisions) attempt to speak with every reporter as soon as possible after the reporter has contacted DHS to report child abuse, if that reporter was not able to speak with an intake worker during the initial contact.
10. DHS clarify policy that any report that is rejected, while there is an open assessment about the same child, should be documented as a rejected intake. If it is a duplicate of a report on which there is an open assessment, the duplicate report should also be documented in the Assessment Summary.
11. DHS emphasize, in policy and in the training of intake workers, the need not only to gather, but also to document information relevant to reported allegations of abuse as completely and accurately as possible.
12. DHS provide additional training to intake workers to better ensure appropriate and consistent decisions are made on intake. [The Ombudsman believes creation of a statewide centralized unit to receive reports and complete intakes (see Recommendation #1) will facilitate appropriate, consistent, and adequately documented decision-making.]
13. DHS ensure that any written notice advising a reporter that the report has been rejected state clearly the specific reason for the rejection. If a report is rejected solely because it is a duplicate of a prior report, the reporter should be informed of that reason, unless this would clearly violate confidentiality laws.
14. DHS accord reporters who are notified that their reports are rejected an opportunity to contact an appropriate designated DHS staff person, such as a supervisor or child protection specialist, if they disagree with the decision or have additional questions about the decision.
15. DHS provide additional training to workers involved in child protection about the signs and indicators of physical abuse, sexual abuse, and neglect, the distinguishing characteristics of accidental versus inflicted injuries, and the mechanisms of injuries; DHS also provide additional training for the identification of substance abuse, particularly the use of methamphetamine and how that impacts family dynamics and child safety.
16. DHS modify policy to require that, in the event DHS refers a child for examination by a physician, the CPW attempt to contact the physician in advance of the examination and inform the physician about the child’s injury or condition, any explanation given for the injury or condition, and other pertinent history concerning the child. If the CPW discovers during the assessment any additional relevant information regarding the cause or explanation for the child’s injury or condition, the CPW should contact and confer with the doctor again.

17. DHS adopt a policy encouraging the use of cameras, bruising color charts, and injury measurement instruments in conducting assessments, whenever possible, to document visible injuries and other evidence relevant to the assessment. All CPWs should be equipped with a camera, a bruising color chart, and injury measurement tools. DHS should also develop and provide an appropriate training curriculum for the use of cameras, color charts and injury measurement tools.
18. DHS clarify policy stating when it is essential or necessary to make a visit to the home in conducting an assessment of the child and the family, and when it may be appropriate to attempt unannounced home visits.
19. DHS and the Iowa General Assembly review the 20-business day time-frame for completion of assessments to determine if it allows adequate time to conduct thorough assessments and complete the written Assessment Summaries. Consideration should be given to allow supervisors and program staff to grant limited extensions in cases when extensions are clearly necessary.

[Although the Ombudsman did not find any evidence to indicate that the 20-business day time-frame for completion of an assessment impacted how Shelby Duis' case was handled, the Ombudsman believes that a rigid 20-day time-frame may be an artificial and potentially counterproductive requirement.]

20. DHS develop a standardized process for recommending and making referrals for DHS services, to assure that recommended services are properly and timely referred and acted upon; DHS develop a separate referral form or revise a current referral form to prominently document the specific services recommended, any priority or urgency in implementing them, and any subsequent actions taken on the recommendations (i.e., approval, assignment, referral, initiation).

DHS should review the process for recommending, referring and initiating services, including completion of necessary paperwork, to find ways to improve the initiation and delivery of services.

21. DHS 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 adopt a policy requiring supervisors to review all relevant information in the assessment file, before approving the Assessment Summary; DHS 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.
22. DHS review how effectively multi-disciplinary teams are functioning across the state and find ways to improve the development and utilization of all multi-disciplinary teams as a resource for CPWs.

23. DHS and other appropriate Iowa officials, such as the Attorney General, the Department of Public Health and the University of Iowa Health Care collaboratively study the accessibility to and the sufficiency of medical child abuse expertise available to DHS child protection staff. Based upon this evaluation, take the necessary steps to provide or obtain such expertise.

OVERVIEW

Background

Shelby Duis was found dead at her home on January 4, 2000. She was 2 years and 9 months old. She resided in a house in Spirit Lake, Iowa with her [redacted], her mother Heidi Watkins, and her mother's boyfriend, Jesse Wendelsdorf. An autopsy found evidence of multiple blunt force injuries to various parts of Shelby's body, some acute and others that were inflicted several weeks and months preceding her death.

Watkins and Wendelsdorf were charged with first-degree murder and felony child endangerment. In addition, Wendelsdorf was charged with first-degree sexual abuse. The child endangerment charge against Wendelsdorf was dismissed. A jury found Wendelsdorf not guilty of the murder and sexual abuse charges on July 28, 2000. Following a bench trial, Watkins was convicted on August 24, 2000 of multiple acts of child endangerment, a class B felony. She was acquitted on the murder charge.

Shelby's death outraged many people in the Spirit Lake area and around the state. Some of the anger was directed at the Iowa Department of Human Services (DHS). Several individuals spoke publicly that they had repeatedly warned DHS that they suspected Shelby was being abused.

Department Of Human Services Internal Review

DHS initiated an internal review on February 2, 2000 to address the concerns expressed by those individuals and to identify any issues related to policy compliance and practice. In a report released to the public on March 3, 2000, DHS pointed out several areas of the child protection system that could be improved upon or should be examined further, including:

- Improve better communication among the parties within the system.
- Ensure good skills training for child protective workers.
- Examine adequacy of staff, job responsibilities and caseloads.
- Improve training of mandatory reporters.
- Expand community resources and services for families.
- Educate the whole community more about how to protect children.

However, DHS concluded the following in its report: "From the review of Shelby's death, we determined that the policies critical to her safety were followed."

Ombudsman Investigation

Citizens' Aide/Ombudsman William P. Angrick II (Ombudsman) commenced an independent investigation after receiving a joint request on February 3, 2000 from Senate President Mary Kramer and Senate Majority Leader Stewart Iverson to investigate the circumstances surrounding Shelby's death and DHS's actions. The Ombudsman received a similar request from Senator Maggie Tinsman on February 7, 2000.

The Ombudsman issued notice of the investigation to DHS Director Jessie Rasmussen on February 10, 2000.¹ The notice said the following:

As you are aware, the office of the Citizens' Aide/Ombudsman has been asked to investigate the Department of Human Services' (DHS) policies and practices in the handling of child abuse allegations regarding Shelby Duis.

Pursuant to Iowa Code Chapter 2C, notice is hereby given that the office of the Citizens' Aide/Ombudsman is initiating a formal investigation in this matter. This investigation shall include, but not be limited to, a review of the actions taken and decisions made by the DHS staff as a result of reported allegations of child abuse.

Included with the notice was a subpoena for documents and records relevant to the investigation.

The Ombudsman assigned the investigation to a three person team: Deputy Ombudsman and Legal Counsel Ruth Cooperrider, the team leader, and Assistant Ombudsmen Don Grove and Wendy Sheetz. For reference purposes in this report, actions taken by any members of the investigative team will be ascribed to the Ombudsman.

Investigative Process

Interviews

The Ombudsman interviewed 46 witnesses under oath, including:

- DHS child protection workers, social work case manager, supervisors and administrators, clerical staff, and persons answering the child abuse hotline.
- The provider of in-home services to Shelby's family under a contract with DHS.
- Persons who contacted DHS concerning Shelby.
- Relatives and friends of Shelby's family.
- Law enforcement officers.
- The Dickinson County Attorney.
- Physicians who treated Shelby.

Follow-up interviews were conducted with some witnesses, after the Ombudsman received new or additional information from other witnesses or documents.

¹ See Appendix A, letter (containing notice of investigation) and subpoena to DHS Director Jessie Rasmussen.

The Ombudsman also considered testimony of relevant witnesses in Wendelsdorf's and Watkins' criminal cases, including that of the pathologist² and another doctor who was present at the autopsy on Shelby, and a pediatric radiologist who examined x-rays of Shelby.

Documents

In addition, numerous documents were reviewed including:

- Relevant Iowa laws, DHS administrative rules and policies.
- DHS internal review reports and attachments (both confidential and public versions).
- DHS child protective intake records, child abuse investigation and assessment reports, service file and photographs.
- Child protective workers' case logs, appointment calendars and time sheets, and training history.
- Basic course training materials for child protective workers.
- Mandatory reporters training videotapes.
- Medical records from Lakes Family Practice and Dickinson County Memorial Hospital.
- Autopsy report and photographs.
- The Judge's Verdict in Heidi Watkins' trial.
- A 1999 "Consultant Report" to the Ombudsman regarding fairness and due process in Iowa's child protection system.

Telephone Records

Because several people were claiming they made repeated calls to DHS concerning Shelby, the Ombudsman decided at the onset that one aspect of the investigation was to ascertain who made what calls. It was clear, from initial interviews with DHS employees and the persons claiming to have made the calls, that verification of all the calls would be difficult. Both the callers and DHS employees had problems recollecting what calls were made and when. Many of the calls were not documented by DHS, although the possibility existed that records of some of the calls had been destroyed as required by law or policy.

Telephone records became an important source of information. The Ombudsman obtained certain monthly telephone billing statements from the callers. Those statements, however, did not show any calls made to toll-free numbers, like the Child Abuse Hotline (Hotline).

In a surprising development, the Ombudsman discovered that DHS's billing records from Iowa Communications Network (ICN) incorrectly documented two calls to the Hotline as occurring in the morning instead of the evening hours. This is discussed in more detail under "Challenges and Constraints" in this section of the report.

² At the request of the Assistant Attorney General involved in prosecuting Wendelsdorf's case, the Ombudsman agreed to withhold taking testimony of the pathologist prior to Wendelsdorf's trial and instead obtained the pathologist's deposition taken in that case.

Medical Consultant

To assist in understanding the signs of physical abuse and sexual abuse and what signs were apparent from photographs of Shelby, the Ombudsman consulted with Rizwan Shah, M.D. Dr. Shah has been the medical director of the child abuse program at Blank Children's Hospital in Des Moines, Iowa since 1989. In that position, she provides medical evaluation and diagnostic services on cases of alleged child abuse, neglect, and drug-exposed infants that are referred to her by DHS, other physicians and legal professionals. She has been assessing child abuse since 1981 and has seen an average of 400 to 600 children a year.

Other sources

- State of Florida's Department of Children and Families; State of Arizona's Department of Economic Security; State of Texas' Department of Protective and Regulatory Services. These states provided information about their centralized toll-free child abuse hotline systems.
- Several articles by medical professionals regarding diagnosis of child abuse, specifically related to bruising and fractures.

Challenges and Constraints

The investigation took more time than originally intended, primarily due to the depth of the review and the challenges and constraints that developed. It was difficult to complete the investigation in a short time frame, because the breadth and complexity of the factual, policy and practice issues necessitated an extensive and thorough review. In addition, the Ombudsman encountered the following challenges and constraints, some of which were unexpected.

Witness Recollection Problems

Most of the witnesses had problems recalling various aspects of many of the reports made to DHS concerning Shelby, whether it was the number of calls, when they were made, and what was said. This was true for both the persons making the reports and the DHS workers. Some callers were quite certain about what they reported, but could not remember exactly how many calls they made or when. The DHS workers sometimes recalled the gist of what was reported, but not when that report was made. Where there were discrepancies between witnesses, the Ombudsman considered other evidence, including telephone records, that corroborated or lent credence to a witness' account.

Insufficient or Lack of Documentation

Persons who are by law mandatory reporters are required to make both oral and written reports. None of the mandatory reporters who made calls concerning Shelby submitted written reports.

Likewise, DHS workers who receive reports of child abuse are responsible for documenting the reports. However, information was not properly documented in some reports on Shelby. There were some situations where a record about a report would have been destroyed as required by law or policy, but the worker could not recall if the record had been made in those instances.

Had these records existed and been available, they would have been useful to the Ombudsman in determining whether DHS made appropriate decisions on reports received.

DHS Unaware of Relevant Documents

- Hotline Contact Report

Although the Ombudsman's subpoena in part required DHS to provide any documents "relevant to any contacts or reports to or any actions taken by the Department, its employees or agents regarding alleged child abuse of Shelby Duis," one significant record was overlooked by DHS. That record was the Contact Report completed by a worker at the State Training School (STS) in Eldora, Iowa, on a report about Shelby to the Hotline the evening of December 12, 1999.

In fact, the head of DHS's Bureau of Protective Services informed the Ombudsman that he was not aware the record existed. Apparently, one of his predecessors had instituted the practice for STS to send the Contact Reports to his office, where they were filed and then destroyed after three months. [Note: That practice was changed August 18, 2000; since then, copies of the Contact Reports are provided to the intake workers in the appropriate local offices.]

The Ombudsman discovered the existence of the Contact Reports the first week in June 2000 during an inquiry to STS about how it handles Hotline calls. The Ombudsman then requested the DHS worker who filed the Contact Reports to look for any reports for December 1999, even though the worker thought the records would have been destroyed by then. The worker, however, did find the Contact Report about Shelby.

- Hotline Telephone Records

The Ombudsman specifically requested DHS to provide any telephone records showing calls to the Hotline, including the numbers from where the calls originated. The response from DHS on April 10, 2000 said, "there is no record of the calls that come in but the 1-800 bill does track where the calls were forwarded."

Two months later, as a result of the Ombudsman's inquiry about the December 12, 1999 calls to the hotline, DHS officials provided billing records (Call Detail) from the Iowa Communications Network (ICN), the agency which operates the state's telephone system, that show the telephone numbers that called the Hotline, the date and time of the calls, and the length of the calls.

Conflicting Telephone Records

Because of discrepancies between witnesses concerning calls allegedly made to the Hotline on December 12, 1999, the Ombudsman subpoenaed Qwest Communications and obtained switch records of two of the witnesses.³ As it turned out, these switch records confirmed the testimony of one of the callers that she made three calls that evening and led to the discovery that ICN's billing records of those calls were incorrect. ICN's billing records showed two of the calls were made in the morning, but further review by ICN of their switch records confirmed they were

³ Switch records reflect the actual calls that go through the telephone company's switch, and therefore provide more accurate data than billing records or statements. In addition, switch records show calls to toll-free numbers. Switch records were obtained for October 21-22, 1999 and December 12-13, 1999.

evening calls. ICN was not able to explain the discrepancies between their billing records and switch records for those two calls.

Resistance to Interviews

[redacted] DHS requested the Crittenton Center, a private entity located in Sioux City, Iowa, to provide family-centered (in-home) services to Shelby's family. The Crittenton Center social worker assigned to the case visited with the family on December 23, 1999. When the Ombudsman asked to interview the social worker, the Crittenton Center, through an attorney, resisted the subpoena on the basis that the information requested of the social worker was privileged under law (Iowa Code section 622.10). To avoid protracting the investigation with a court action, the Ombudsman agreed to request only information that the attorney did not consider to be privileged.

The Ombudsman also faced an obstacle in obtaining information from the pathologist who conducted Shelby's autopsy. The prosecuting attorneys were concerned about the pathologist giving testimony prior to being deposed or testifying in Wendelsdorf's trial. Therefore, the Ombudsman agreed to wait for a transcript of the pathologist's deposition in the criminal case.

In addition, the Ombudsman sought to reinterview a doctor and to speak with a hospital [redacted] worker regarding their contacts with DHS, after discovering new information from telephone records. The attorneys representing two individuals did not respond to the Ombudsman's written requests for interviews of those individuals.

Investigative Report

Sections of Report

The Ombudsman's investigative report is divided in ten sections. The first section, entitled "Overview," discusses the background leading to the investigation, including Shelby's death and DHS's internal review of its involvement with Shelby. It then gives an overview of the Ombudsman's investigation, including how the investigation was conducted, what information was gathered and reviewed, and what challenges and constraints were encountered.

The second, third, fourth, and fifth sections of the report provide more background and overview information about the state's child protection system. A general understanding of that system, especially DHS's role, is necessary to determine whether DHS workers acted properly and reasonably in Shelby's case. The laws and DHS rules, policies and procedures referenced in the sections are those that were applicable at the time of DHS's involvement with Shelby. These sections are not exhaustive discussions of the reporting, intake, and assessment processes, but are general overviews with selective summaries of subjects relevant to issues in this investigation.

The second section gives an overview of the role that DHS plays in child protection. It also explains the structure DHS operates within in fulfilling its role and responsibilities.

In the third section, "Reporting Process," the Ombudsman discusses how child abuse gets reported and the system that DHS has set up for receiving those reports.

The fourth section explains, “Intake Process,” how DHS generally gathers information on a report of child abuse and determines whether to initiate an assessment of the abuse allegation and the family situation.

The fifth section, “Assessment Process” explains what DHS does in an assessment to ascertain whether child abuse has occurred and evaluate the family and home environment, to determine what, if any, actions or services are needed to protect the child and assist the family.

A lengthy chronology of relevant events, from the time DHS first became involved with Shelby’s family until her death and autopsy, is contained in the sixth section. Also included in the chronology are the Ombudsman’s findings of what occurred with respect to what was reported to DHS and how DHS responded to those reports.

The Ombudsman references in the seventh section relevant information and opinions from Dr. Rizwan Shah, a medical doctor with whom the Ombudsman consulted as part of the investigation.

In the eighth section, “Analysis and Conclusions,” the Ombudsman applies relevant laws, rules, policies, and practices to the findings and draws conclusions on the issues that were investigated.

The ninth section contains the Ombudsman’s “Recommendations.”

The tenth section is a selected Appendix of documents or other information referenced in the report.

Focus of Report

The Ombudsman is charged with the responsibility to investigate administrative actions that may be contrary to law, rule, or policy, or that may be unreasonable, unfair, or inconsistent, even though they were in accordance with law, rule, or policy. The Ombudsman may also be “concerned with strengthening procedures and practices which lessen the risk that objectionable administrative actions will occur.”⁴ Given this statutory role, the Ombudsman concentrated in this report on those policies or practices that the Ombudsman found to be questionable or inappropriate, and that could be improved or strengthened.

However, it should be noted that the Ombudsman found many actions or decisions of DHS workers to be appropriate. There were some about which the Ombudsman could not offer an opinion or conclusion because information was lacking or contradictory, or evidence did not reach the preponderance standard used by the Ombudsman in making findings and reaching conclusions. The Ombudsman’s report does not focus on these actions or decisions.

Nor did the Ombudsman investigate in depth and reach any conclusions about the reviews conducted by the local DHS supervisor, the multi-disciplinary team, or the county attorney on the specific assessments involved. The Ombudsman does comment and make recommendations about local supervision and multidisciplinary teams in Iowa's child abuse system generally. No

⁴ Iowa Code section 2C.11(5).

issues or concerns were raised or identified regarding local law enforcement agencies' specific role in Shelby's case. Due to jurisdictional limitations, the Ombudsman did not make any conclusions or recommendations regarding the professional or occupational actions or decisions of the private individuals who attended to or evaluated Shelby, including the daycare providers, the in-home services provider, and the family physicians.

Effect of Confidentiality on Report

Iowa Code section 2C.9 allows the Ombudsman to have access to confidential child abuse information for purposes of an investigation. However, that same provision also prohibits the Ombudsman from disclosing confidential child abuse information. Therefore, the Ombudsman also had to decide what information could be legally disclosed publicly in this report.

Complicating this decision was a new state law which went into effect on April 21, 2000. One section of the new law opened access to the Governor, a member of the General Assembly, or a designated employee of the General Assembly to child abuse information relating to a case of fatality or near fatality. The public was also granted access to the same information, subject to certain specified exceptions.⁵ The Ombudsman conferred with DHS officials and a Deputy Attorney General representing DHS regarding what information was covered under the new law.

Although the new law enables the Ombudsman to discuss in the report a great deal of information about Shelby which was confidential before April 21, 2000, there is other child abuse information which is still confidential by law that the Ombudsman cannot include in the published report. In addition, there is confidential personnel information that is not included in the report.

⁵ 2000 Iowa Acts, House File 2377, section 9.

Department of Human Services Role and Organization

Children in this state are in urgent need of protection from abuse. It is the purpose and policy of this part 2 of division III to provide the greatest possible protection to victims or potential victims of abuse through encouraging the increased reporting of suspected cases of abuse, ensuring the thorough and prompt assessment of these reports, and providing rehabilitative services, where appropriate and whenever possible to abused children and their families which will stabilize the home environment so that the family can remain intact without further danger to the child.

--Iowa Code section 232.67⁶

DHS Role in Child Protection

Iowa's child protection system consists of many players. The system includes DHS, people in the community who may report abuse, others who must report abuse like child care providers, physicians, law enforcement, county attorneys, and the juvenile court.

DHS has a significant and critical role in protecting Iowa's children. The Iowa Legislature established a "program for the prevention of child abuse" within DHS and charged it with the responsibility for receiving and assessing reports of child abuse, and taking steps necessary to ensure that the child involved is safe.⁷

When DHS receives a report, an intake is conducted to determine if the report should be accepted for an assessment. An assessment is then completed to determine if child abuse has occurred, to evaluate the child's safety and the family's strengths and needs, and to decide if steps need to be taken to ensure the child's safety or to involve the family in services. The processes for receiving reports, doing intakes and conducting assessments are discussed in more detail in subsequent sections of this report.

DHS Organization

DHS's central office is located in Des Moines, Iowa. Its field operation and local offices in the 99 counties are organized into 5 regions and 38 clusters. Some counties with larger populations are by themselves clusters. Other counties are grouped together to form clusters.

Structurally, DHS is divided into several divisions. The Division of Adult, Children, Family Services (Division) administers an array of services for children, dependent adults, and families. The division's Bureau of Protective Services (Bureau) manages the child protective services program, the central abuse registry (Registry), and the central abuse hotline (Hotline).

⁶ Iowa Code chapter 232, Division III, Part 2 is entitled "Child Abuse Reporting, Assessment, and Rehabilitation."

⁷ Iowa Code section 235A.1; Iowa Code chapter 232, Division III, Part 2.

However, the workers who handle child abuse intakes and assessments are not within the Bureau or Division. These workers are part of DHS's field operation, which includes the county, the cluster, and the regional offices.

Each region has a Regional Administrator, who oversees the operation of the cluster and county offices. Each region also has a Protective Services Program Specialist, whose responsibilities include staff training and consultations, reviewing a number of completed assessment reports and rejected intakes, and assisting in the development and implementation of policies.

Each cluster is based in a county office. Its operation is directed by a Human Services Area Administrator (HSAA). Each cluster has social workers who assess reports of child or dependent adult abuse. For this report, these workers are referred to as child protection workers (CPW). The CPWs and other social workers who handle service cases (Case Manager)⁸ report to one or more supervisor(s). The supervisor(s) in turn reports to the HSAA. In some clusters the HSAA, supervisor(s) and CPWs are not housed together in the same office.

Dickinson County, where Shelby Duis resided, is in the Sioux City Region. It is part of a four-county cluster that also includes Clay, Osceola and O'Brien counties. The cluster is based in the Clay County office, which is located in the city of Spencer (Spencer Cluster). There are two CPWs in the cluster and one supervisor. The CPWs, supervisor, and HSAA all work out of the Spencer Cluster office, and travel to other counties or county offices in the cluster as necessary.

⁸ The case managers who provide and arrange services are housed in each county office.

REPORTING PROCESS

This section discusses how child abuse was reported under Iowa law and the DHS policies and procedures that existed at the time of DHS's involvement with Shelby Duis. Generally, that process remains the same at present.

Reporting Child Abuse

Who May or Must Report

Iowa law provides that any person who believes a child has been abused may make a report to DHS.⁹ DHS administrative rule defines a "report of child abuse" as "a verbal or written statement made to the department by a person who suspects that child abuse has occurred."¹⁰

If the report is made to any other agency, the agency is to "promptly refer the report to the department of human services."¹¹

Certain persons are mandatory reporters if, in the scope of their professional practice or employment responsibilities, they examine, attend, counsel, or treat a child, and reasonably believe the child has been abused.¹² These persons include peace officers, health practitioners, social workers, and employees or operators of licensed child care centers. Mandatory reporters must make a report within 24 hours.

Method of Reporting

Reports by mandatory reporters must be made both orally and in writing to DHS. The written report has to be made within 48 hours of the oral report.¹³

DHS has a form which mandatory reporters may use to file the written report.¹⁴ According to the DHS's Employees' Manual (DHS Manual),¹⁵ workers are to advise mandatory reporters of their responsibility to submit written reports and offer to furnish a copy of the form.

Permissive reporters (those who are not mandated by law to report) may make either an oral or written report, or both.

⁹ Iowa Code section 232.69(2).

¹⁰ 441 I.A.C. 175.21(232,235A).

¹¹ Iowa Code section 232.70(6).

¹² Iowa Code section 232.69(1).

¹³ Iowa Code section 232.70(1), (3).

¹⁴ See Appendix B, *Report of Suspected Child Abuse*, Form 470-0665.

¹⁵ Iowa Department of Human Services, *Employees' Manual*, Title 16, Chapter E (Revised July 1, 1997). The July 1, 1997 version was in effect when DHS was involved with Shelby Duis. It was revised on January 11, 2000.

What to Report

Iowa Code section 232.70 provides that reports should contain the following information or as much of the information that the reporter is able to furnish:

- The names and home address of the child and the child's parents or other persons believed to be responsible for the child's care;
- The child's present whereabouts if not the same as the parent's or other person's home address;
- The child's age;
- The nature and extent of the child's injuries, including any evidence of previous injuries;
- The name, age and condition of other children in the same home;
- Any other information which the person making the report believes might be helpful in establishing the cause of the injury to the child, the identity of the person or persons responsible for the injury, or in providing assistance to the child; and
- The name and address of the person making the report.

A report from a permissive reporter, even if it does not contain all of this information, is still to be regarded by DHS as a report.

Mandatory reporters are required to complete two hours of training relating to the identification and reporting of child abuse within six months of their employment, and at least two hours of additional training every five years. Depending on their work situation, mandatory reporters can obtain the training through their employer or as part of a continuing education program or a training program offered by DHS or other public agency. DHS has produced a "Child Abuse Mandatory Reporter Training" videotape that is available for use by mandatory reporters.

Receipt of Reports

DHS does not have a centralized unit or single point of contact for receiving abuse reports. Iowa Code section 235A.14 does require DHS to "maintain a toll-free telephone line, which shall be available on a twenty-four hour a day, seven-day a week basis and which the department of human services and all other persons may use to report cases of suspected child abuse and that all persons authorized by this chapter may use for obtaining child abuse information." However, all oral reports do not *have* to be made to the Hotline.

DHS administrative rule 441-175.22(232) provides that reports "shall be received by county department offices, the central abuse registry, or the Child Abuse Hotline." The general process is to get each report to a worker who is responsible for completing an intake on the report. Intake is the process of obtaining information from a reporter to determine whether an abuse assessment should be initiated. Most reports are made by telephone. The workers who answer the Hotline do not do intakes. How a report gets to the person doing intakes depends on where the call is placed, when it's made, (during or after business hours), and the county involved.

Reports During Business Hours

One way to report abuse is through the Child Abuse Hotline (Hotline). It is also known as the Central Abuse Hotline because it also handles abuse reports concerning dependent adults.

Calls to the Hotline during regular business hours are answered by staff at the Central Abuse Registry office (Registry). If the line is busy, calls can roll over to two other numbers.

Calls sometimes may be to other numbers at the Registry. In either situation, the worker who answers the call will ascertain if the call is to report abuse. If it is, the call is then transferred to the appropriate county DHS office where the CPWs are located for intake.

Reports of child abuse can also be made directly to DHS's county offices. Who handles calls that come into the county offices, whether they are transferred or made directly there, varies across the state, depending on regional policy and county set-ups. Generally, a receptionist answers all incoming calls to a county office. Once the receptionist determines that the call is to report abuse, it is directed to the appropriate worker to take the report. Some more heavily populated counties, which may by themselves be clusters, have workers who are designated to do intakes during business hours. Most counties do not have workers doing intakes fulltime.

Sioux City Region

The Sioux City Region has a written policy outlining who is responsible for receiving reports and completing intakes on the reports.¹⁶

According to that policy, reports concerning a child should be taken by a CPW (whose job class is Social Worker III). If no CPW works in that office or one is not available, the call is taken by another person in the following order of availability: Supervisor of the CPWs; other Social Worker III, Supervisor, or the Human Services Area Administrator (HSAA); Social Worker II; clerical staff. This protocol is followed in every county office in the region, except for Woodbury County and Webster County, which have designated staff who receive and handle intakes.

If a person calls the Dickinson County office to make a report about a child in that county, the caller would speak to whomever is available in accordance with the above protocol. The information is then immediately provided to a CPW in the Spencer Cluster office (i.e., Clay County office), to complete the intake and decide if the report should be rejected or accepted for assessment. If a CPW is not available, it is referred to the supervisor. If a supervisor is unavailable, the CPW is paged, and if there's no response, the HSAA is contacted.

If the person calls the Hotline instead, the process varies slightly. After the Hotline worker ascertains the call is to report abuse, the worker transfers the caller to the Spencer Cluster office. The transfer is done "blindly", which means the worker does not speak to anyone at the office receiving the transfer. The receptionist at that office speaks with the caller and again determines the purpose for the call. Then the receptionist transfers the caller to the CPW or whomever is available to complete the intake in accordance with policy.

¹⁶ Sioux City Region's *Policy and Procedure Guideline Memo, S-07*.

Reports After Business Hours

Outside of business hours the Child Abuse Hotline number, along with the two roll-over numbers, are forwarded so calls are answered at the State Training School (STS) in Eldora, Iowa. The STS is a residential facility for male juvenile offenders that is run by DHS. The STS workers who receive the Hotline calls are not trained as intake workers; they function more like an answering service.

If the STS worker believes a person is making an abuse report, the worker takes down the information and completes a contact report form.¹⁷ After the call, the STS worker pages the CPW who is on call that day for the county where the child resides. When the CPW calls the Hotline back, the STS worker relays the information to the CPW. The CPW then tries to call the reporter to complete the intake.

If the on-call CPW does not call the Hotline worker back within 15 minutes after a page, the CPW is to be paged again. If there is still not a return call in 30 minutes, the CPW is again paged. However, if the report seems urgent, the Hotline worker is to contact the on-call supervisor.¹⁸

The contact reports completed by the STS workers on the Hotline are not provided to the CPWs. They are sent to and filed at the Registry for three months, after which they are destroyed.¹⁹ [The Ombudsman notes that, since the middle of August 2000, copies of the Contact Reports are faxed to the appropriate local offices where the CPWs are situated.]

Most clusters also direct reporters who call after business hours (after-hours) to contact the Hotline. However, not all clusters use the Hotline as the point of contact for after-hours calls.

For example, the Des Moines Region (consisting of 10 counties in 6 clusters) has its after-hours calls answered by the Central Iowa Chapter of the American Red Cross, Inc.²⁰ The Red Cross workers are instructed to get as much information as possible on every call regarding the alleged abuse and persons involved. The workers then page the designated on-call coordinator, who calls back for the information and completes the intake on the report. The Red Cross staff write the information on a contact report form and also enter it into their computer system. They do not provide the contact reports or computer data to DHS, unless specifically requested by DHS.

¹⁷ See Appendix C: contact report form, *Child-Dependent Adult Protective Investigations Contact Report*; DHS' State Training School procedures, *How to take a Hotline Call*.

¹⁸ See Appendix C, DHS's State Training School procedures, *How to Page an Abuse Worker*.

¹⁹ DHS has no written policy regarding the filing or retention of the Contact Reports from STS. The Ombudsman learned from the employee in the Bureau of Protective Services who files the Contact Reports that the procedure is to retain the filed Contact Reports for three months and then destroy them.

²⁰ The after-hours hotline services for the Des Moines Region are provided by the Central Iowa Chapter of the American Red Cross, Inc., under a contract with the Polk County DHS Office.

Sioux City Region

All after-hours child abuse reports in the Sioux City Region are taken by the Hotline. Each county DHS office has an answering machine that refers persons wanting to report abuse to the Hotline.

Thus, anyone calling the Dickinson County office or the Spencer Cluster office (i.e., Clay County office) to report abuse after hours will be directed to call the Hotline number. The Hotline worker at the STS will take down the caller's information, or at least the reporter's name and telephone number. The caller then hangs up and waits for the Hotline worker to page the on-call CPW, for the CPW to contact the Hotline worker, and for the CPW to call the reporter back.

Intake Process

This section provides an overview of what occurs during the intake process, as provided by Iowa law and DHS rules and policies. Most of the policies are from the DHS Manual.²¹

Intake is the process by which DHS workers gather information from a reporter and determine whether an assessment should be initiated.

The DHS Manual states:

The primary purpose of intake is to obtain available and pertinent information regarding a report of child abuse. An intake worker's ability to gather this information is critical to the assessment process and is the first step taken to initiate safeguards for children at risk.

Intake workers must be flexible and be able to communicate effectively with callers through asking questions, recording necessary information, and discriminating between significant and extraneous information.

Advantages of completing the intake task thoroughly include improved safety for children, more complete information at the outset for the assigned worker, and improved public awareness of the Department's roles and responsibilities. Danger to a potential victim and civil liability to the Department are greater without appropriate intervention.²²

Criteria for Assessment

Iowa law requires DHS to initiate an assessment if a report constitutes an allegation of child abuse.²³

“Child abuse” is defined as:

- a. 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.
- b. Any mental injury to a child's intellectual or psychological capacity as evidenced by an observable and substantial impairment in the child's ability to function within the child's normal range of performance and behavior as the result of the acts or omissions of a person responsible for the care of the child, if the impairment is diagnosed and confirmed

²¹ All references to the DHS Manual are to the version that was revised July 1, 1997. Where the DHS Manual is referenced, the language marked by the bullets comes from the DHS Manual.

²² DHS Manual, *supra*, at p. 19.

²³ Iowa Code section 232.71B(1).

by a licensed physician or qualified mental health professional as defined in section 622.10.

- c. The commission of a sexual offense with or to a child pursuant to chapter 709, section 726.2, or section 728.12, subsection 1, as a result of the acts or omissions of the person responsible for the care of the child. Notwithstanding section 702.5, the commission of a sexual offense under this paragraph includes any sexual offense referred to in this paragraph with or to a person under the age of eighteen years.
- d. The failure on the part of a person responsible for the care of a child to provide for the adequate food, shelter, clothing or other care necessary for the child's health and welfare when financially able to do so or when offered financial or other reasonable means to do so. A parent or guardian legitimately practicing religious beliefs who does not provide specified medical treatment for a child for that reason alone shall not be considered abusing the child, however this provision shall not preclude a court from ordering that medical service be provided to the child where the child's health requires it.
- e. The acts or omissions of a person responsible for the care of a child which allow, permit, or encourage the child to engage in acts prohibited pursuant to section 725.1. Notwithstanding section 702.5, acts or omissions under this paragraph include an act or omission referred to in this paragraph with or to a person under the age of eighteen years.
- f. An illegal drug is present in a child's body as a direct and foreseeable consequence of the acts or omissions of the person responsible for the care of the child.²⁴

Under Iowa's child abuse laws, a child is "any person under the age of eighteen years."²⁵

A "person responsible for the care of the child" is defined as:

- a. A parent, guardian, or foster parent.
- b. A relative or any other person with whom the child resides and who assumes care or supervision of the child, without reference to the length of time or continuity of such residence.
- c. An employee or agent of any public or private facility providing care for a child, including an institution, hospital, health care facility, group home, mental health center, residential treatment center, shelter care facility, detention center, or child care facility.
- d. Any person providing care for a child, but with whom the child does not reside, without reference to the duration of the care.²⁶

²⁴ Iowa Code section 232.68(2).

²⁵ Iowa Code section 232.68(1).

²⁶ Iowa Code section 232.68(7).

Gathering Report Information

To assist the worker in deciding whether a report is an allegation of child abuse, the DHS Manual instructs gathering as much information as possible from the reporter in the following areas:

- **Child:** Name, home address, current location, age, physical condition, injuries, previous injuries.
- **Parents:** Name, home address, current location.
- **Caretaker:** (if other than parent) Name, address, current location.
- **Person responsible** for the alleged abuse: Name, address, current location.
- **Other children:** Name, age, and condition of other children in the same household.
- **Incident:** Condition of child, other children in household, and other household members; conduct and condition of parent, caretaker, or person responsible for the alleged abuse; and the cause of child's condition.
- **Miscellaneous:** Names, phone numbers, and addresses of persons knowledgeable about the child's circumstances.
- **Reporter:** Name, phone number, address, and relationship to the child and incident being reported.

The DHS Manual states not all of this information may be available. It advises workers to carefully ask questions regarding each of these areas.

In-depth Intake

The purpose of an in-depth intake is to obtain additional information to ensure that reports requiring assessment are accepted and reports that do not meet the criteria are appropriately rejected.

Only the initial reporter or mandatory reporter(s) who may have knowledge of the incident or the child's circumstances can be contacted during the intake process to obtain additional information or to clarify information relevant to the report. The intake worker cannot contact the parent, child or any non-mandatory reporters. To make such contacts, an assessment must be initiated.²⁷

The DHS Manual provides that, if an in-depth intake is conducted, the worker must contact the initial reporter or mandatory reporter(s) by the end of the next working day following receipt of the report.

Intake Decision

After the intake worker has gathered as much relevant information as possible, the worker must decide whether the information meets the criteria for assessment. If it does not meet the criteria to be assessed, the report is rejected.

²⁷ 441 I.A.C. 175.24(232).

According to the DHS Manual, for a report to result in an assessment, “it must include some information to indicate all of the following:

- The alleged abuse occurred to a child.
- The alleged abuse was caused by acts or omissions of a person responsible for the care of the child.
- The alleged abuse falls within the definition of child abuse.”²⁸

The DHS Manual also states that, in order to reject a report of suspected child abuse, the worker “must obtain sufficient information to be able to determine that abuse has *not* happened.”²⁹

The DHS Manual advises, “It may be possible to make reasonable inferences that would cause a case to be accepted for assessment based upon descriptions of certain abusive activities.”³⁰

Even if a report is rejected because it does not meet the criteria for assessment, the intake worker can:

- Advise the informant that the family may apply for services through the Department.
- Refer the informant to appropriate community based services, or refer the report information to an ongoing services unit.
- Contact law enforcement if the child’s safety appears to be in jeopardy or if the information alleges illegal activity.

According to the DHS Manual, a decision to reject a report must be made within 72 hours of receiving the report.³¹

Review by Supervisor

A supervisor reviews the intake and makes the final decision to reject the report or to assign it for assessment. Rejected intakes must be approved by a supervisor.

Once a report has been accepted for assessment, the supervisor is to assign it to a CPW within 24 hours of receipt of the report, unless an in-depth intake is conducted.

²⁸ DHS Manual, *supra*, at p. 19.

²⁹ DHS Manual, *supra*, at p. 23. This statement has been replaced with the following language in the DHS Manual, as revised January 11, 2000: “The intake worker must obtain sufficient information to be able to determine if the intake criteria have been met.” However, the current DHS Manual also adds the following statement with respect to allegations of physical abuse: “Accept the report for assessment unless there is no doubt that the injury was accidental.”

³⁰ DHS Manual, *supra*, at p. 21.

³¹ The DHS Manual, as revised January 11, 2000, no longer contains the 72-hour time frame provision. A written policy change issued by the Bureau on September 12, 2000 requires the decision to accept or reject a report to be made within 1 hour, if the report indicates a child has suffered a “high risk” injury or there is an immediate threat to the child, and within 12 hours, if the allegations do not present a “high risk.”

Documenting Report and Decision

The report information must be documented on a “Child Protective Services Intake” form (Intake Form).³²

The decision or disposition on the intake is also documented. The options are: report rejected, report accepted, or referred for services.

If the report is rejected, the reason(s) for the rejection must also be stated. The date, time, and the name of the supervisor approving the rejection must also be documented on the Intake form, or the information must be attached to it. When a reporter is notified of the rejection decision, that action is also to be noted.

The rejected intakes are retained at the local assessment unit for six months and then destroyed.

Copies of all rejected intakes are forwarded to the appropriate county attorneys.

Notifying Reporter of Decision

The DHS Manual requires the intake worker to notify the reporter if the report is rejected and the reason(s) why (i.e., the missing criteria). The worker must also inform the reporter that a supervisor will review and make the final decision about accepting or rejecting the report. If this notice is not provided during the initial contact with the reporter, a supervisor or designee must then make reasonable efforts to notify the reporter.

Sioux City Region’s policy states, “It is the responsibility of the Protective Services Worker to notify all reporter(s) whether or not a referral meets legal criteria for Assessment/Evaluation.”³³

[*Note:* A new law that went into effect April 21, 2000 requires DHS to inform reporters within 24 hours of the report whether or not DHS has initiated an assessment.]

³² See Appendix D, *Child Protective Services Intake* (Rev. 1/99). Beginning April 2000, intake information is entered into the DHS computer system.

³³ Sioux City Region’s Policy, *supra*.

Assessment Process

This section provides an overview of the steps or actions involved in completing a child abuse assessment, as provided by Iowa law and DHS rules and policies. The DHS Manual is the source for most of the policies.³⁴

Child protective assessment is the process by which DHS “carries out its legal mandate to ascertain if child abuse has occurred, to record any findings, to develop conclusions based upon evidence, to address the safety of the child and family functioning, engage the family in services if needed, enhance family strengths and address needs in a culturally sensitive manner.”³⁵

Transition From “Investigation” to “Assessment”

The process to determine if child abuse has occurred used to be called an “investigation.” Assessment pilot projects started in late 1995. Statewide implementation of the change from investigations to assessments began in 1997 with different counties or clusters changing over at different times during the next year and a half. The Spencer Cluster, which includes Dickinson County, transitioned to the assessment model in January 1998.

The major difference between assessments and investigations is that investigations primarily focused on investigating the alleged incident of abuse. Assessments contain a second component, requiring the CPW not only to investigate the allegation of abuse, but also to evaluate the family’s strengths and needs.

Purpose of Assessment

The DHS Manual states:

The primary purpose of the assessment is to evaluate the risk to the safety of the child and to take action to protect and safeguard the child when necessary. Make contact with the family in all assessments. Other assessment activities vary, depending upon your evaluation of the child’s safety and the family’s strengths and needs.

Based upon the information presented to you at intake and information that you discover and develop during the assessment process, you and your supervisor determine the exact response that will be made. An incremental response to the variety of reports of child maltreatment is possible during the assessment process. The appropriate response for each family depends upon the unique characteristics of each situation. The purpose of each response is to:

- Assess the safety of the child.
- Take necessary steps to increase the child’s safety.

³⁴ Like the “Intake Process” section, all references to the DHS Manual are to the July 1, 1997 version. Where the DHS Manual is referenced, the language marked by the bullets comes from the DHS Manual.

³⁵ 441 I.A.C. 175.21(232,235A).

- Identify appropriate services or supports for the family.³⁶

Documentation of Assessment Information

The information gathered during an assessment is documented in a “Child Protective Assessment Summary” form (Assessment Summary).³⁷

Evaluation of the Alleged Abuse

The first part of the assessment process involves gathering information about the allegation of abuse. Ensuring the child’s safety is the primary reason for evaluating the alleged abuse. The DHS Manual describes this evaluation in five parts:

- Observation and interviews with the child, family members, or others.
- Gathering documentation.
- Assessing safety.
- Determining if abuse occurred.
- Determining if a report meets criteria for placement on the Central Abuse Registry.

Observation

Observation requirements, according to the DHS Manual, depend upon the level of risk to the child posed by the allegation. The DHS Manual instructs CPWs to consider the following factors:

- Use of confidential access.
- The location of the child.
- The location of the person responsible for the abuse.
- Coordination with law enforcement or licensing authorities.

The DHS Manual allows a CPW to delegate the observation of the child to other DHS casework staff, if necessary. The DHS Manual instructs staff to follow local administrative procedures when this is done, and to document the date and time the child was observed, and who observed the child.

When there is an immediate threat to the child’s safety, the worker is to “make reasonable efforts to observe (physically view) the child within **one hour** of receiving the intake call.”³⁸ When the report is a serious injury allegation, or a child is at high risk for a serious injury, staff should act quickly to ensure the child’s safety. The following are examples of serious situations:

- Deep lacerations requiring medical attention.

³⁶ DHS Manual, *supra*, at p. 25.

³⁷ See Appendix E, *Child Protective Assessment Summary, Part A, Part B* (Rev. 7/97). The information is entered into a computerized version of this form.

³⁸ DHS Manual, *supra*, at p. 28.

- Fractures, including skull fractures.
- Intentionally inflicted burns.
- Any physically abusive incident (even minor) to an infant.
- Multiple adult bite marks or adult bite marks that penetrate the skin.
- Young children left alone or with a dangerous caretaker.
- Threatening a child with knives or guns.
- Sexual abuse.

If these circumstances exist, the CPW also needs to develop a plan that ensures the person or persons responsible for these circumstances do not have access to the child until a more thorough evaluation is completed. This may include contacting law enforcement to help safeguard the CPW and the child from potential danger during the assessment or to do an emergency removal of the child. (Emergency removals are discussed later in this section.)

In situations that do not appear to involve an immediate threat of serious harm, CPWs are instructed to attempt to observe the child within 24 hours of receipt of the complaint. If a CPW and supervisor jointly determine from the report information that the child is not at risk of further abuse, observation may be delayed for up to 72 hours, or it may be determined observation is not necessary. If such a determination is made, the CPW is required to document the rationale behind this decision. The DHS Manual provides examples of circumstances when observation may not be necessary, but cautions they are extremely limited circumstances.

Observation of a child under four years old may include viewing the child's unclothed body, except the genitalia and pubes. The DHS Manual states that CPWs should not attempt to view injuries near the genitalia area, unless the parent or guardian gives permission.

CPWs are instructed to "carefully describe and document all injuries observed, including the exact location, size, color, and shape" and to "note the child's and caretaker's explanation as to how each injury occurred."³⁹

Confidential Access

CPWs should observe and interview the child at the same time they interview the parent(s). If the CPW needs to observe the child away from the parental home, in most cases the CPW needs to attempt to obtain parental consent. The DHS Manual outlines the following situations in which it may be necessary to observe the child prior to obtaining parental consent:

- The parents have a history of violence or flight.
- The alleged person responsible for the abuse is the child's parent or guardian or resides in the child's home, and the injury or risk of injury may be significant.
- The child's condition requires immediate observation.
- You believe that the child would be in danger of abuse if the parent or guardian is first contacted.
- You believe that the integrity of information obtained during the assessment would be jeopardized if the parent or guardian is first contacted.

³⁹ DHS Manual, *supra*, at p. 30.

- Children need attention or placement assistance, and the parents' whereabouts are unknown.

If a CPW observes a child without parental consent, the CPW is to make reasonable efforts to contact the parent on the same day the observation of the child occurred, except when doing so would endanger the child or others. The CPW is to also make reasonable efforts to obtain supervisory approval when accessing a child without parental consent.

The CPW is to document in the Assessment Summary the date and time that contact is made, and any unsuccessful efforts to contact the parent. The CPW is also required to document in the Assessment Summary the rationale for accessing the child without parental consent.

Interviews

The DHS Manual identifies interviewing the child, family, and others who might have information about the report of suspected child abuse as another tool to evaluate the safety of the child. CPWs are to focus the questions on issues or concerns raised in the child abuse report and on the assessment of the strengths and needs of the child, parent, home, family, and community. CPWs are encouraged to use "open-ended" questions, which cause a person to give more than a "yes" or "no" answer.

The Manual requires CPWs to make reasonable efforts to contact the person believed to be responsible for the alleged abuse, to give that person the opportunity to respond to the allegations. Documentation of a CPW's attempt to find this person and offer to interview the person is to be included in the Assessment Summary.

CPWs are to attempt to contact and interview other individuals who may have relevant information regarding the alleged abuse and the assessment of the child's safety.

Contacts with Examining Physicians and Experts

Iowa law provides that if DHS "refers a child to a physician for a physical examination, the department shall contact the physician regarding the examination within twenty-four hours of making the referral."⁴⁰ If the examination or any medical test has not yet been completed, DHS Manual instructs the CPW to contact the physician again before completing the assessment.

The DHS Manual also instructs the CPW to do the following: "Make any medical or other professionals contacted for consultation aware of the explanation the subjects of the report have given for the injury. Ask the professional consulted if the injury is consistent with the explanation."⁴¹

If the professionals contacted provide different opinions about the cause of the injury or the child's condition, CPWs should try to resolve the differing opinions through asking additional questions of the professionals and explaining the other opinion offered. If there is still no

⁴⁰ Iowa Code section 232.71B(8).

⁴¹ DHS Manual, *supra*, at p. 35.

agreement, CPWs should obtain additional professional opinions or consult with supervisory staff, regional protection specialists, and program staff.

CPWs may consult with experts who have particular knowledge regarding the abuse report. Experts include those involved in medicine, psychiatry, psychology, and law enforcement. In addition, CPWs may obtain helpful evaluative information from textbooks, journals, or other publications.

Gathering Documentation

Documentation can assist CPWs in determining if abuse occurred, assess the family's strengths and needs, and develop a suggested plan of action. The DHS Manual discusses six types of information or documentation.

Descriptions

CPWs are told to describe the relevant objects observed during the assessment, and where possible, link the description to the allegation.

Photographs

CPWs may take photographs to show injuries or to document conditions in the home, especially those cases that are likely to result in placement on the Registry. CPWs are to document the date and time the photograph was taken. Police departments and hospitals are other common sources for photographic documentation.

CPWs and mandatory reporters do not need parental permission before taking a photograph during an assessment or before a mandatory reporter makes a report.

Copies of the photographs may be attached to the Assessment Summary.⁴²

Medical Reports and Records

CPWs are to obtain medical reports and records that pertain to the information being assessed. These include findings from physical or sexual abuse examinations, x-rays or relevant medical tests. This information is to be summarized in the written assessment report, and the medical reports are to be attached to the written Assessment Summary (see footnote #42).

Reports from Child Protection Centers

DHS contracts with several child protection centers around the state to interview child abuse victims and to provide medical evaluations and psychosocial assessments of those children. CPWs should summarize reports prepared by child protection centers related to the child's physical, mental and emotional status in the Assessment Summary, and attach the reports to the Assessment Summary (see footnote #42).

⁴² DHS Manual, as revised January 11, 2000, provides that copies of photographs, medical records, and reports from child protection centers are not attached to the Assessment Summary, but maintained in the assessment case file.

Other written reports

CPWs should seek other written reports, such as mental health evaluations, treatment records, criminal records, law enforcement reports, when they are relevant to the report allegations. CPWs should summarize any significant information in the written assessment report and clearly identify the source of the information.

Tapes, Transcripts, or Summaries

If a CPW has videotaped or audiotaped parts of the assessment, these tapes and transcripts are to be kept as part of the case file documentation.

Evaluating the child's safety

After completing all necessary observations and interviews, and gathering the necessary documentation, the CPW must evaluate the child's safety and risk for occurrence or re-occurrence of abuse.

The DHS Manual lists factors to consider in evaluating continued risk of the child named in the report, any other children who live in the same house, and any other children whom the person responsible for the abuse may have access to. These factors are:

- Severity of the incident or condition.
- Chronicity of the incident or condition.
- Age of the child.
- Attitude of the person responsible for the abuse regarding its occurrence.
- Current services or supports for the child and family that address the abuse incident or risk.
- Factors contributing to the abuse.
- Access of the person responsible for the abuse to the child.
- Protectiveness of the parent or caretaker who is not responsible for the abuse.

If a CPW believes a child is not safe, the CPW is to document that belief in the Assessment Summary. In addition, the CPW is to document efforts taken to secure the child's safety, such as requesting the filing of a "Child in Need of Assistance" petition, seeking removal of the child with law enforcement assistance, or requesting a treating physician to temporarily hold a child. (See discussion later in this section regarding "Emergency Removal.")

Determining if Abuse Occurred

The CPW next determines if abuse occurred, based upon the legal criteria for a finding of abuse. CPWs need to assess the credibility of everyone interviewed in making this determination.

The Child Protective Handbook (Handbook), developed by DHS, lists the factors that must be present in order for the CPW to determine that child abuse occurred. Those factors vary depending upon the type of abuse. CPWs first must determine that a preponderance of evidence collected confirms that child abuse occurred. They are then required to address each factor, specific to the type of abuse, and provide supporting evidence for each in the Assessment

Summary. When an allegation involves more than one type of abuse, the Assessment Summary should address each type of abuse, and document that the appropriate factors for each type of abuse were considered.

The Handbook requires two factors to be present with any type of abuse:

- The presence of a child victim, *and*
- The presence of a person responsible for the abuse who was a caretaker to the child.

The DHS Manual instructs CPWs to identify the child subject and person responsible for abuse in the Assessment Summary. More than one person may be identified as responsible for the abuse. If the CPW is unable to determine who is responsible for the abuse, the CPW may indicate that the identity of the person responsible for abuse cannot be determined.

The CPW can make one of three determinations on each allegation of abuse:

- “Founded” - This means that a preponderance of the evidence (51% or greater) indicates that child abuse has occurred, and the circumstances meet the criteria for placement on the Registry.
- “Confirmed abuse not placed on the Registry” - This means that a preponderance of evidence indicates that child abuse has occurred, but the circumstances did not meet the criteria for placement on the Registry.
- “Not confirmed” – This means that there was not a preponderance of evidence indicating that child abuse occurred.

The term “preponderance of evidence” is defined in DHS rules as “evidence which is of greater weight or more convincing than the evidence which is offered in opposition to it.”⁴³

Iowa law provides that a confirmed report shall not be placed on the Registry if DHS “determines the injury or risk of harm to the child was minor and isolated and is unlikely to reoccur.” It also specifies the circumstances when the confirmed report is to be placed on the Registry as a “founded” case.⁴⁴

The CPW is to document all circumstances that require placement of an incident on the Registry.

Description of the Family’s Strengths and Needs

The second part of the assessment involves a comprehensive evaluation of the strengths and needs of the child, the child’s parents, home, family and community. The DHS Manual requires

⁴³ 441 I.A.C. 175.21(232,235A).

⁴⁴ Iowa Code section 232.71D(2).

an evaluation of the family's strengths and needs for every assessment in the following situations:

- Ongoing services through the Department are initiated.
- A family is already receiving Department services.
- The family requests an assessment.

CPWs are to encourage a family's participation in the evaluation and make reasonable efforts to complete an assessment to evaluate the family's strengths and needs in the following situations:

- The family and child are not receiving required or desired services or support, or
- There are circumstances which place the child at risk for abuse. This may include conditions affecting the child, the caretaker, the home, or other entities that pose a risk for an abuse to occur.

If the family refuses to cooperate with the evaluation, the CPW is to do a brief assessment of the child, the parents, the home environment, and the social environment.

Interviews

CPWs are to interview the family and others who have relevant information to complete the evaluation. The CPW should explore with the child and family members factors that would enhance the family's functioning and improve safety for the child. Additionally, the CPW should work with the family to develop a plan of action.

DHS Manual lists four factors a CPW should consider when conducting an evaluation. Each factor has a number of areas the CPW should discuss or evaluate with the family. The four factors are:

- Home environment characteristics....[11 areas outlined]
- Parent or caretaker characteristics....[37 areas outlined]
- Child characteristics....[15 areas outlined]
- Social and environmental characteristics....[9 areas outlined]

Home Visits

The assessment may include a visit to the home of the child, if the parent or guardian consents.

The DHS Manual states:

In most cases, a visit to the home is essential in conducting an assessment of the child and family. Only a parent or guardian may provide permission to enter the child's home, unless you are conducting the home visit jointly with law enforcement and a law enforcement officer directs you to enter the home. A substitute caretaker may provide permission to enter the substitute caretaker's home.

When you conduct an assessment at an out-of-home setting, (such as a day care center or residential facility), assess the family and environment where the alleged abuse occurred. It may be necessary to include an assessment of the child's own home and family relationships to develop a suggested plan of action.⁴⁵

Recommendations

The assessment process includes the CPW discussing with the family supports or services that are available and may benefit the family. CPWs are told to offer the least restrictive supports and services that will promote the child's safety and improve family functioning.

If the family is already receiving services through the DHS, the CPW is to contact the family's case worker and service providers in order to gain their assistance in evaluating the abuse report as well as the child and family functioning. The CPW is told to assess the effectiveness of the service and recommend additional services, if necessary. The four levels of action plans the CPW can suggest as outlined in the DHS Manual are:

- No service need identified.
- Development of informal supports.
- Services or supports provided by community agencies or organizations.
- Department services recommended.

Additionally, the CPW may make a recommendation for juvenile or criminal court action.

If the family refuses the suggested services, the CPW should consult with the supervisor regarding the risk factors in the home. If the supervisor and CPW believe services are necessary to protect the abused child, the CPW is instructed to follow local procedures in referring the child and family for juvenile court involvement.

Completion of Assessment Summary

Iowa law requires CPWs to have the written Assessment Summary completed within 20 business days of receipt of the report.⁴⁶ There is no process to extend this timeframe. If the assessment is not concluded within that time, the DHS Manual instructs CPWs to document in the Assessment Summary the information that has been obtained, then complete the assessment, and write any additional information in an addendum to the Assessment Summary.

⁴⁵ DHS Manual, *supra*, at p. 49.

⁴⁶Iowa Code section 232.71B(11)(b).

The Assessment Summary is divided into two parts.

Part A of the Assessment Summary contains the “report and disposition data.” It is the CPW’s evaluation and analysis of:

- The abuse allegations as reported to the Department.
- Any other protective concern or abuse discovered during the assessment process.

The DHS Manual outlines 20 areas that the CPW must address in Part A. The CPW is also required to include any relevant information from any previous DHS contacts with the child or family.

Part B of the Assessment Summary contains the “assessment data.” It is the CPW’s assessment of how the child and family are functioning.

In addition to the evaluation of the child and family’s functioning, if unmet needs are identified, the CPW should identify the strengths and needs of:

- The child.
- The child’s parent or caretaker.
- The children in the home.
- The social and environmental characteristics.

Part B is to include a suggested plan of action to meet any identified needs along with the CPW’s reasons for recommending the plan. It should also indicate the child and family’s willingness to accept services.

The DHS Manual instructs CPWs to destroy any rough notes that were created during the assessment process once the report has been completed.

A supervisor reviews and approves each completed Assessment Summary.

Notification of Assessment Summary

Upon completion of the Assessment Summary, the CPW is required to provide written notice of its completion and findings (founded, confirmed not placed on the Registry, not confirmed) to:

- All subjects of a child abuse assessment, including the child alleged to have been harmed, the parents or guardians of the child, and the person alleged responsible for the abuse.
- A mandatory reporter of the report that had been assessed.
- A child protection center that conducted interviews during the assessment process at DHS’s request.
- A DHS worker who conducted a courtesy interview for the assessment at the request of the CPW.

If an addendum is completed at a later date, the CPW is required to send written notice of the addendum and the findings to those persons.

A copy of Part A of the Assessment Summary is provided to the juvenile court and the county attorney in every case.

Emergency Removal

The DHS Manual instructs CPWs to continuously assess a child's safety during the assessment process as it relates to the report of alleged abuse. CPWs are to consider recommending removal of the child from the person responsible for the abuse when the CPW determines the following:

- The child is imminently likely to suffer significant physical or emotional harm, unless the child is separated from the person responsible for the abuse, and
- In-home services, such as family preservation or family-centered services, will not adequately safeguard the child, or are not available.

When possible, CPWs are to consult with supervisory staff before making such a recommendation. If consultation is not possible due to the emergency nature of the situation, the CPW is to notify supervisory staff of the recommendation as soon as possible.

There are two options available for CPWs to separate the child from the person responsible for the abuse. One is removal of the child, and the other is removal of the person responsible for the abuse. CPWs are to assess which option would provide the most safety and the least disruption to the child.

Under Iowa law, a peace officer or juvenile court officer may take a child into custody, a physician may keep a child in custody, or a juvenile court officer may authorize a peace officer, physician or medical security personnel to take a child into custody, without a court order and without the consent of a parent, guardian, or custodian, if both of the following apply:

- The child is in a circumstance or condition that presents an imminent danger to the child's life or health.
- There is not enough time to apply for an order under section 232.78.⁴⁷

The DHS Manual reminds CPWs they do not have legal authority to remove a child from the home, without the consent of the parent, guardian, or custodian. If a CPW believes a child is imminently likely to suffer significant injury or death unless the child is removed from the home, the CPW is to immediately contact a peace officer and request assistance. If the peace officer refuses to assist with the removal, the CPW is to follow local procedures to request the juvenile court for an ex parte order to remove the child.

⁴⁷ Iowa Code section 232.79(1).

Similarly, the CPW can request a treating physician keep a child in custody, and if the physician refuses, the CPW can request an ex parte order from the juvenile court.

According to the DHS Manual, all the following criteria must exist before requesting an ex parte order to remove a child:

- In home services to protect the child are unavailable or are not sufficient to alleviate the risk to the child.
- It appears that the child's immediate removal is necessary to avoid imminent danger to the child's life or health.
- Either:
 - The person responsible for the care of the child is absent; or
 - The person responsible for the care of the child refused to consent to the removal of the child and was informed of the intent to apply for an order to remove the child; or
 - There is reasonable cause to believe that a request for removal will further endanger the child or cause the caretaker to take flight with the child.
- There is not enough time to file a petition and hold a juvenile court hearing.

The DHS Manual provides steps may be taken, in accordance with local procedures, to request removal of the person responsible for the abuse from the home in the following situations:

- There is a report of sexual abuse or physical abuse, and
- There is a belief that the child's separation from the person responsible for the abuse is necessary to prevent the child from suffering immediate and significant harm.

Any action taken regarding removal or requests for removal is to be documented in the Assessment Summary.

Chronology of Events and Ombudsman's Findings

Introduction

The Ombudsman's investigation involved a review of DHS's policies and practices in handling child abuse allegations regarding Shelby Duis, including actions taken and decisions made by DHS employees as a result of the reported allegations of child abuse. A necessary component of the investigation was to determine what contacts or reports were made to DHS.

This section presents the actions and events the Ombudsman believes were significant and relevant to this review in a chronological format. These included DHS's involvement not just with Shelby, but with her family before her birth. Because some of the events and actions extend different time periods, there are some overlaps in the chronology.

The chronology is a composite of the Ombudsman's findings regarding what occurred on reports to DHS -- who contacted DHS, how and when the contact was made, what was told to DHS, and how DHS responded. The chronology is an effort to establish the Ombudsman's composite understanding that best describes what happened and was said. This composite draws from multiple sources and testimony given at different times.

Where the Ombudsman discovered conflicting evidence regarding a material factual issue, the Ombudsman discusses what evidence was considered and how the finding was reached. These findings are in italics. Also italicized are findings by the Ombudsman regarding actions *not* taken by DHS that are relevant to this review. The Ombudsman made these findings based upon a preponderance of the evidence (greater than 50%).

In some records quoted from by the Ombudsman in this report the spellings of Heidi (Watkins), [redacted] ([redacted]), and Jesse (Wendlesdorf) varied. When the Ombudsman quoted from those records the spelling of Heidi, [redacted], or Jesse were left as they were and the Ombudsman did not draw attention to the misspelling by insertion of a (sic).

Chronology

September 1, 1990

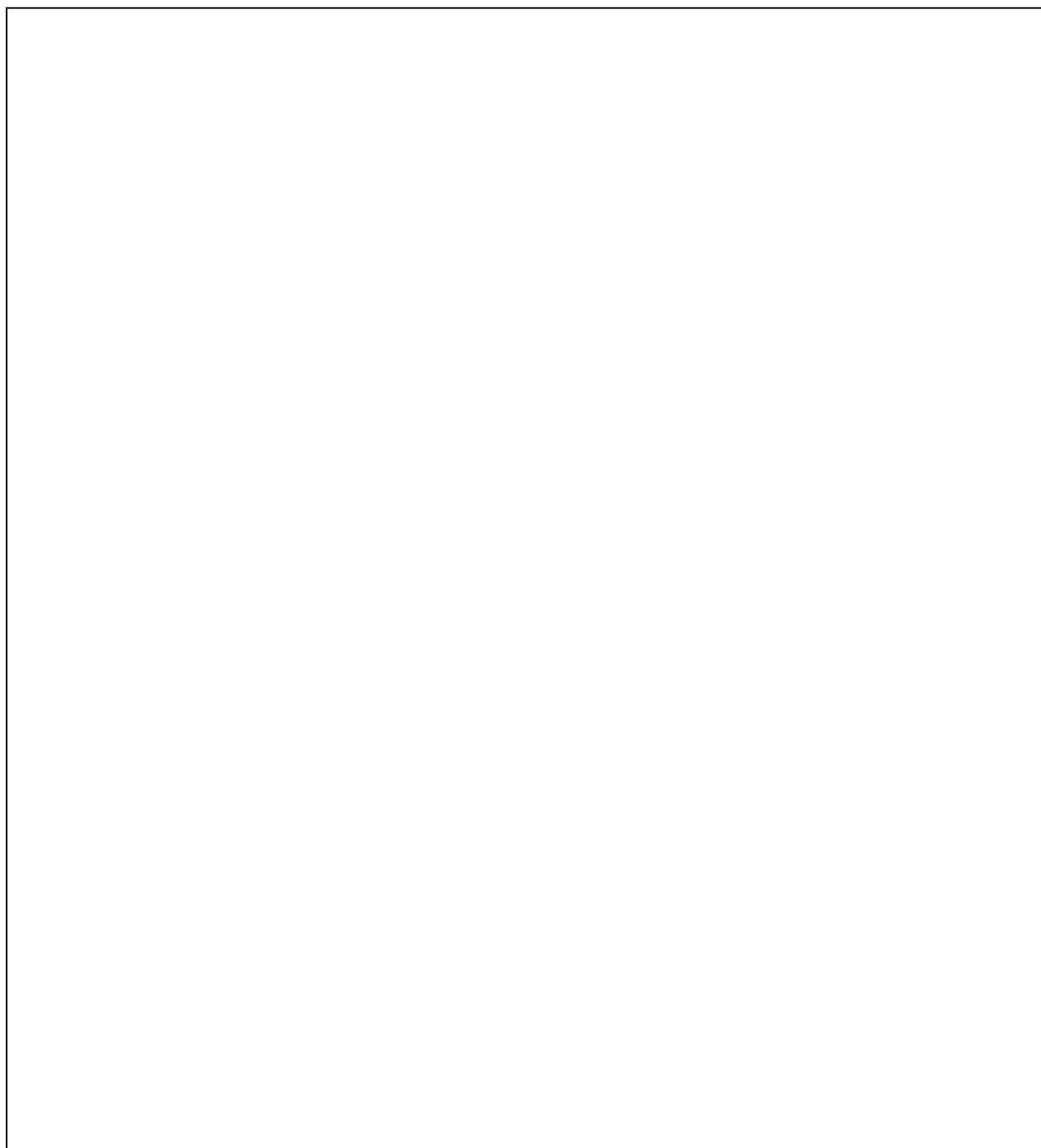
Heidi Watkins and Troy McKnight were married.

August 14, 1991

[redacted] McKnight was born.

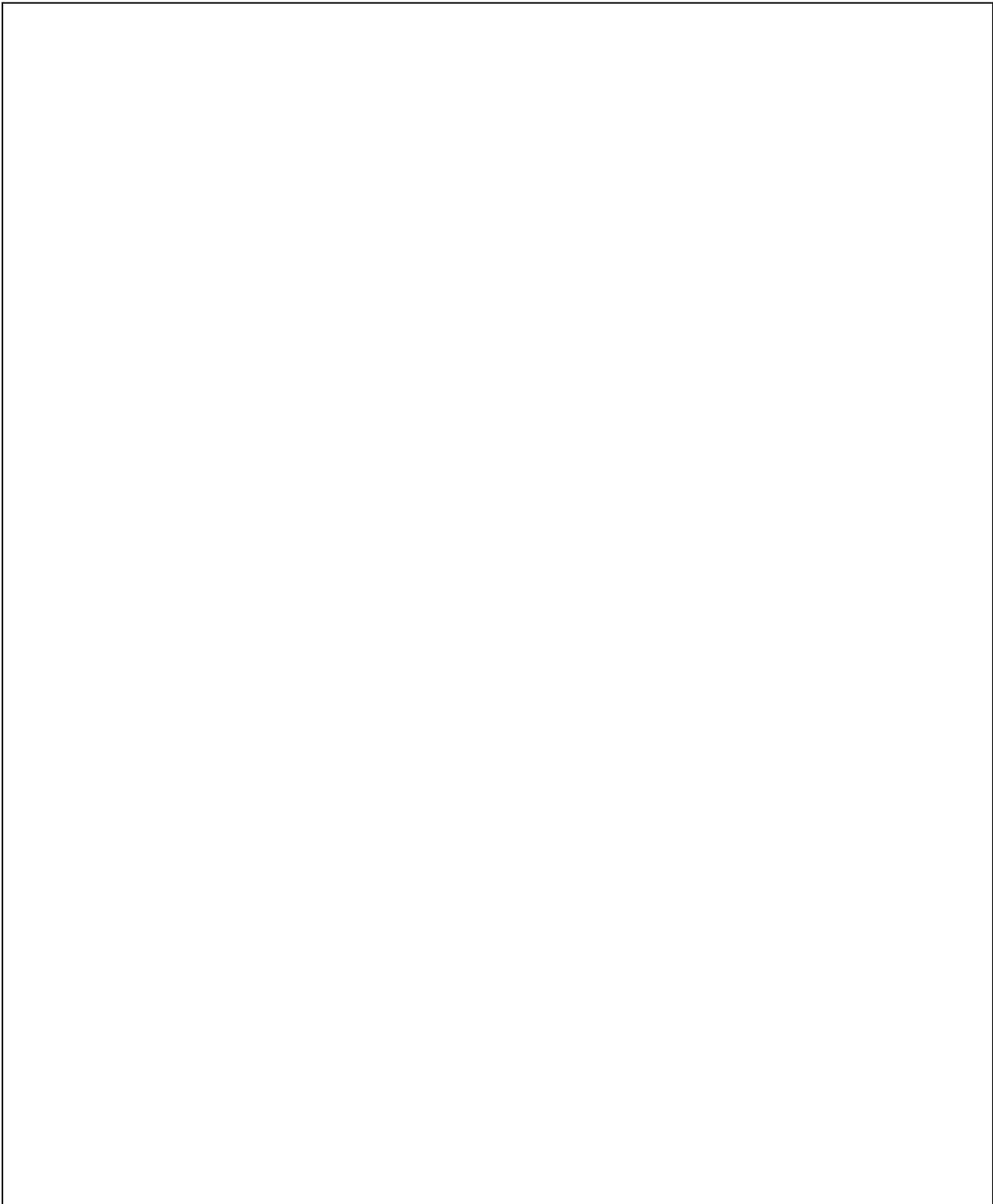
June 1994

Heidi and Troy McKnight separated.



1995

Watkins and Kevin Duis began living together.



Early 1997

Heidi Watkins and Kevin Duis' relationship ended.

March 29, 1997

Shelby Duis was born.

June 11, 1997

Watkins was charged on June 11, 1997 in a trial information by Assistant Dickinson County Attorney Bethany Brands with two counts of possession of controlled substances, namely methamphetamine and marijuana, and one count of child endangerment, all serious misdemeanors.

October 1997Report from Deb Gosch

Deb Gosch, Area Education Agency (AEA) caseworker, testified that an informant told her of concerns on October 22 and 28, 1997. According to contact logs Gosch completed on those dates, the first time the informant talked about an incident that occurred the past weekend, which Gosch wrote down. The second time the informant told her more information about Shelby. Gosch offered to call Illg. Gosch testified that she called Illg each of those two days, after she returned to her office.

Gosch provided the Ombudsman a copy of a page from her notebook which listed the concerns she jotted down from the informant, most likely on October 22, 1997. Gosch testified she relayed to Illg those concerns, which included: Last Friday night, Watkins left six-month-old Shelby home alone; last Saturday night, Shelby had "poopy diapers dried on," Watkins was drunk, and there was moldy food and gnats all over the house. Gosch also told Illg something about "drugs" and feeding "reg milk vs. formula."

The informant told the Ombudsman that some of the information she told Gosch she knew firsthand and other information Terri Phelps told her.

Report from Terri Phelps

Terri Phelps was living in an apartment above Watkins at that time. Phelps regularly visited Watkins and sometimes babysat for her children. She testified she called DHS sometime in October to report an incident that occurred the previous night. She said she had seen Watkins leave and then she heard Shelby crying. She knocked on Watkins' door, and when no one answered, she walked in and found the children alone. She said this occurred sometime between midnight and 2:00 a.m.

Phelps testified she initially spoke with a female, then later that day Illg came to her apartment. She said she told Illg about two incidents when Watkins left the children home alone -- the one that had occurred the previous night and another that had occurred a week earlier. She said the first time Watkins was gone 15-20 minutes and the second time she was gone two hours. Phelps also testified she told Illg that when she babysat the children, sometimes she had "to bring food from [her] house to feed them" and one time she found a bowl of spaghetti "totally molded."

Intake

Illg did not recall receiving nor doing an intake on either of Gosch's reports. He testified that, had he received them, they would have been handled as intakes and documented. He stated, "What I can only assume now is that that was not accepted for an investigation."

Illg recollected receiving a report from Phelps only after the Ombudsman mentioned her name and asked if he had ever visited her apartment building. He recalled Phelps telling him about Watkins leaving her children alone without a babysitter. He then met with Phelps at her apartment. He testified Phelps had concerns about Watkins leaving her children alone, but she did not discuss any particular incident when she actually found the children by themselves in Watkins' apartment.

Illg said he did not accept Phelps' report because she couldn't say for sure the children were in fact home alone. He said Phelps only had suspicions.

Gosch did not recall Illg informing her whether he was accepting her report. Phelps said all Illg told her was "thanks for contacting me and if you see anything else, call."

DHS has no documentation of the calls. Even assuming Illg had documented the intakes and his supervisor had approved their rejection, record of them would no longer exist. Under DHS policy, records of rejected intakes are destroyed after six months.

Gosch said she considered herself a mandatory reporter, but she did not submit a written report on either call. She testified that, at a later date, she went to the local DHS office and asked if she should file a written report, and Phyllis Slawson, a supervisor in the office, told her she didn't need to "due to the fact [she] was a reporter of a reporter." Even if she had submitted a written report and the report had been rejected as an intake, the written report would have been destroyed along with the rejected intake after six months, under DHS policy.

The Ombudsman finds that, in October 1997, Illg received three calls concerning Watkins' care of her children. Gosch made two calls and Phelps made one call. In those calls, Gosch and Phelps individually made a report of child abuse to Illg as they testified to the Ombudsman. Their reports told about at least one specific incident when Watkins left her children home alone during the night. The testimonies of Gosch, Phelps, and the informant were substantially consistent, and Gosch's contemporaneous notes corroborated the information reported to Illg.

The Ombudsman further finds that Illg did not accept Gosch's report and Phelps' report for investigation. The Ombudsman is unable to determine whether Illg documented and obtained supervisory approval of the reports as rejected intakes. Due to the reporters' uncertainty and the unavailability of documentation, the Ombudsman is unable to determine whether Illg informed Gosch or Phelps of his decision.

June 19, 1998

On June 19, 1998 the charges filed a year before against Watkins were dismissed by a district court judge, after Assistant Dickinson County Attorney Brands filed a motion to dismiss. The motion stated that Watkins had “complied with the terms of the plea agreement.”⁴⁸

October 1998

In October 1998, the divorce action between Heidi Watkins and Troy McKnight was finalized.

November 1998

In November 1998 Watkins and her children, [] and Shelby, moved into a single family house at 1501 Jackson Street in Spirit Lake.

December 1998

Tara Hansen, an employee of Small World Child Care Center (Small World) in Spirit Lake, testified she called the Clay County DHS Office twice in December 1998 to report possible abuse of Shelby. Hansen said her name was Tara Walling at the time.

Hansen said in her first call, she spoke with a woman and told her she was calling to report suspected neglect. She said she told the woman that a little girl had come in with “no coat” and was “absolutely filthy.” She said the woman told her she would have a caseworker call her back as soon as possible, but no one returned her call.

Hansen said she made the second call a week or a week and a half later, when she saw bruises on the backs of Shelby’s legs midway between the knees and buttocks that matched a handprint. She said she left a message on an answering machine, in which she identified the child as Shelby Duis and requested someone to call her back. She said no one returned her call.

Hansen said that she spoke with co-worker Kristy Linn about Shelby before each call and that Linn saw the handprint bruise. However, Linn testified she did not remember Hansen making the calls nor seeing the bruises on the back of Shelby’s legs.

Neither Illg nor Kerrie Morey, the other CPW in the Clay County DHS Office, remembered any call from Hansen concerning Shelby. DHS has no documentation of either call.

Small World’s telephone records show two calls were made to the Clay County DHS Office in December 1998.

Date	Time	Minutes	From	To
12-1-98	9:05 a.m.	12	Small World	Clay County DHS
12-8-98	12:15 p.m.	1	Small World	Clay County DHS

Although the telephone records seem to support Hansen’s statement that she made the calls to the Clay County DHS Office, there is no other evidence to corroborate the calls were made by

⁴⁸ Brands told the Ombudsman that Watkins never entered a plea nor was there a formal plea agreement; she believed what probably occurred was that prosecution was deferred and the case was eventually dismissed, based on Watkins’ compliance with the law and other expectations they may have set for her over the year.

Hansen. Karen Roseberry, the owner of Small World, told the Ombudsman that her staff called that office occasionally about other children. Linn did not recall seeing the injury on Shelby's legs nor Hansen calling DHS about Shelby. Therefore, the Ombudsman is unable to find or determine whether Hansen contacted DHS in December 1998, as she alleged.

February 22 – March 22, 1999 (Report, Intake, Assessment)

The first report of child abuse concerning Shelby that resulted in an assessment by DHS was received on February 22, 1999. The written "Complete Assessment Summary, Parts A and B" (Assessment Summary)⁴⁹ is dated March 22, 1999.

Report and Intake

An Intake form completed by Illg documented that he received a report of child abuse at 9:10 a.m. on February 22, 1999. He recorded that "Shelby has a black eye" and "there is questionable bruising around the eye." Illg accepted the report and was assigned to complete the assessment.

Kristy Linn, an employee of Small World, testified that she had called Illg and made the report.

Assessment - Determination Whether Abuse Occurred

- Observation of Shelby

According to his Assessment Summary, Illg observed Shelby at Small World at 12:40 p.m. He described the injury as "a bruise, approximately the size of a nickel, which is very faint." He noted that there was "some discoloration underneath Shelby's left eye."

Illg's Assessment Summary did not note any linear bruises. Staff at the child care center thought otherwise. Linn testified, "To us it looked intentional ... [W]hen you put your hand up to it ... you could just see...." Lynann Burns, another employee, testified, "But each and every one of us. Right in front of [Illg]- put our hands up like this...[I]t just looked like someone had hauled off and smacked her or punched her...."

Illg testified he did not see any injury that suggested Shelby had been struck with the sides of a hand. He did not think the childcare staff told him the bruise looked like a handprint.

- Photographs

Illg took five photographs of Shelby's face when he observed her.

From the photographs, the Ombudsman discerned the following visible facial injuries:

- Red and blue crescent shaped discoloration under left eye extending from corner to corner.
- Two linear areas, moderate in size with light purple and brownish discoloration located over left cheek.

⁴⁹ See Appendix F, *Child Protective Assessment Summary Part A; Child Protective Assessment Summary – Part B*. This is the version prepared by DHS for public release, with redactions of information that DHS believed to be confidential by law.

- Very small reddish discolored area located over left forehead near the hairline.
- Two small green discolored areas located on the left portion of the forehead above the left eye.

The Ombudsman finds that the photographs show linear bruises that are consistent with what Small World's staff testified they saw on February 22, 1999.

- Interviews - Explanation for Injury

Illg interviewed Linn, [] and Watkins. Shelby's verbal communication skills were limited, and she could not say what caused her injury.

According to Illg's Assessment Summary, Linn told him that [] said Shelby's injury resulted from her running into Watkins' bedroom door. Linn also told Illg, "Shelby is not accident-prone ... Shelby walks very good and is very steady on her feet."

[] account was that the accident happened when [] and Shelby were running around the house "in a circle from room to room." She told Illg that, right after it happened, Watkins put up a piece of plywood between the dining room and her bedroom door to keep the children from opening the door and running in circles.

Watkins' explanation differed some from [] She told Illg that [] was not home at the time. She said there were other children playing at her house, and they were chasing each other around the house. She said Shelby ran into the doorframe on her own bedroom door. She said she did not see the accident happen, but heard Shelby crying. She said two of Shelby's playmates told her how it happened.

The Ombudsman notes that Illg's account of Watkins' explanation differs from what she later testified to at her criminal trial. At her trial, Watkins testified that she was not home when Shelby sustained the injury. She said one of the children playing at her home was babysitting Shelby, and it was she who told Watkins what had happened.

She [Tiffany] would always invite her friends over to baby-sit. My house was like the neighborhood hangout for the kids. I always had three or four extra kids at my house playing. I don't remember where I had gone, but I had come home and Tiffany said that -

The Ombudsman finds that Illg did not interview the playmates or their parents to verify Watkins' explanation. He accepted Watkins' explanation even though she said she did not see the injury occur.

- Examination of Physical Evidence

Illg's Assessment Summary said he examined the doorframe and found it "notched and grooved." After talking with Watkins, seeing the doorframe, and noting the bruise isolated on the cheekbone, Illg concluded the injury was accidental. He stated, "If the injury was caused by Shelby being slapped, this worker would expect to see additional bruising on the left side of Shelby's face."

The Ombudsman finds that Illg did not closely examine and measure the doorframe to determine if the grooves or notches matched the bruises on Shelby's face.

Assessment - Evaluation of Family Functioning

Illg discussed in Part B of his Assessment Summary the family's history and functioning.

He noted Linn told him that "she was concerned because there appears to [be] an increase in bruises the past two weeks.... Heidi has a new boyfriend and maybe the new boyfriend is not treating Shelby the way he should.... Shelby has hit and punched the ... other children...." Watkins acknowledged to Illg she had a boyfriend but said her boyfriend did not live with her and had never been alone with Shelby or [redacted].

The Ombudsman finds that Illg did not identify Watkins' boyfriend. Nor did he inquire further (e.g., ask [redacted]) to determine if the boyfriend lived with Watkins or ever was a caretaker for her children. He accepted Watkins' statement without any verification.

Illg did not follow-up on Linn's assertion, "Shelby has hit and punched the other children," as a possible sign of a change in Shelby's behavior. He did not make any further inquiries regarding whether Shelby's behavior had changed and, if so, whether the changes may be indicative of abuse.

Determination and Recommendation

Illg determined the report of physical abuse to be unconfirmed, with a finding that the injury was accidental. The Assessment Summary was approved by Phyllis Slawson.

There was no recommendation for any Juvenile Court intervention nor any services for Watkins' family through DHS.

Part A of the Summary, pertaining to the determination whether child abuse occurred, was sent to the Dickinson County Attorney, Juvenile Court, and the Registry.

Spring and Summer 1999

Linn testified she called Illg twice from Small World to update him on Shelby's situation. She could only recall that the calls were made sometime after the black eye report (which occurred February 22, 1999) and the "bloody diaper" incident (which occurred September 13, 1999.)

Linn said she told Illg that the bruises were continuing, Shelby was still being aggressive, and she was very dirty and coming in with the same clothes she had on the previous day. Linn said Illg indicated he was interested in her information and thankful she called.

Small World's telephone records, from March 1, 1999 to September 13, 1999 show two calls to Illg's home and one call to Clay County DHS.

Date	Time	Minutes	From	To
5-3-99	8:15 p.m.	2	Small World	Illg's home
5-3-99	8:18 p.m.	2	Small World	Illg's home
7-29-99	10:27 a.m.	1	Small World	Clay County DHS

When questioned about the two calls to Illg's home in the evening, Linn said she did not know whether she ever called Illg at home or in the evening, but it was possible.

Roseberry remembered Linn calling Illg at least once, "just to tell him how her actions were, to keep him abreast of what was going on in the daycare ...just to keep him notified as to the changes that was going on in Shelby's life."

Illg testified he did not remember receiving any calls from Linn after the February 22, 1999 black eye report. Illg said he visited Small World on May 3, 1999 as part of an assessment regarding another child. He said his case file indicated he received one call from Roseberry at his home on May 3, 1999 concerning that child. Illg's case log for April 1999 shows he had an open assessment on that child on that date.

Given Linn's vague recollections and lack of corroborating evidence, the Ombudsman is unable to find or determine that Linn made the two "update" calls to Illg, as she alleged.

August 27, 1999

Shelby was examined on August 27, 1999 by Dr. Thomas Kalkhoff at Lakes Family Practice, a medical clinic adjacent to the Dickinson County Memorial Hospital.

Dr. Kalkhoff's notes said Shelby had "blisters on her legs and 1 blister in her inguinal area on her R [right] side." He also noted, "These appear to be infectious in etiology."

Dr. Kalkhoff testified that they appeared to be from "poor hygiene." He said Shelby had a type of diaper rash. He was concerned that Watkins was keeping the diaper on too long or she was not cleaning the area adequately. He said he did not suspect abuse.

The medical records indicate he told Watkins to "Keep these areas clean." He also prescribed a topical antibiotic ointment and an oral antibiotic.

Watkins, in her criminal trial, testified that Shelby had "a regular diaper rash" until September of 1999, when she developed a more serious, blistery rash.

The first time I took her into the doctor it was September. They were like little watery blisters. They would pop and it would get real sore and real raw looking. I would use the antibiotic cream, and they would start healing up. They were very tender, and so I was putting udder balm on them because it seemed to cool it, and Shelby seemed to like it better when I used that.

September 13, 1999

On September 13, 1999, staff at Small World discovered Shelby's diaper was saturated with blood. Lynann Burns called Lakes Family Practice. She testified she told the nurse at the doctor's office she suspected sexual abuse. Burns said she noticed marks on Shelby's inner thighs, which she thought were cigarette burns.

However, no staff person at Small World called DHS to report possible abuse. Burns explained she did not think she needed to since she reported it to Shelby's family doctor.

Didn't have any reason to. I called the doctor. He's a mandatory reporter. That should have been his job....

I reported it to who I thought was the proper person. That would be a family physician....

I figured if he didn't see any abuse ... then maybe I was wrong.

Kristy Linn notified Watkins, who took Shelby to the doctor that day. According to Karen Roseberry, owner of Small World, "Heidi came in, gave us some diaper rash medicine and said [Shelby] had a diaper rash."

Dr. Kalkhoff's progress notes for September 13, 1999 said:

Presents with blood in her stools. This was noticed at Day Care this AM. She was treated a couple of weeks ago for a couple of infectious lesions in her R inguinal area. These have now cleared and dried up, however she has developed a new one in her rectal area just superior to the rectum in the rectal crease.

On exam of this she has about a quarter sized ulceration there with redness and cracking just superior to that. I feel that this is where the blood is coming from. Exam of the diaper shows bright red blood along with the stool that is dark but is not black and there is not actual blood in the stool.

Dr. Kalkhoff testified he did not suspect abuse or neglect. He did not see any vaginal or rectal tearing or bruising. He said the blood was coming from the lesion, not internally. He believed the problem was related to hygiene.

Dr. Kalkhoff again prescribed a topical antibiotic ointment and an oral antibiotic, and directed Watkins to clean it with "good soapy water with antibacterial soap after each diaper change." He also ordered a re-check in one week. However, Watkins did not bring Shelby back for a re-check.

Mid-September 1999

In mid-September 1999, Jesse Wendelsdorf moved in with Heidi, , and Shelby.

Watkins testified at her criminal trial her relationship with Wendelsdorf became more than just friendship by May 1999, and by September 1999 he had moved his belongings into her home.

He just started staying over at my house on a regular basis. He would stay there like five or six nights out of the week. Eventually he just moved in with me.

September 29 - 30, 1999

Report from Karen Roseberry

Marcia Stoever, a DHS employee who is a childcare licensing consultant, testified she received a call the morning of September 29, 1999 from Roseberry at Small World. Stoever said Roseberry initially asked her about Small World's licensing status, and then Roseberry and Linn talked with her about Shelby, whom they suspected of being abused.

According to Stoever's contemporaneous notes, they told her of the following concerns:

- Bruises on the face, bruise on ear, bruise on right cheek.
- Grab marks on left jaw.
- Split lip; cut below and inside the lip.
- Scratch on face that was infected and swollen.
- Bloody nose at home that morning.

Stoever asked Roseberry if there was an explanation given for the injuries, and Roseberry said Watkins told her Shelby and a playmate had fallen off the couch.

Roseberry's call to Stoever is corroborated by Gwen Dressel, who was at Small World on September 29 and 30, 1999 to observe in order to write a report for a community college course. Dressel testified she overheard Roseberry telling Stoever about the bruises on Shelby's face.

Roseberry and Linn testified they did not recall speaking with Stoever about the injuries. However, Stoever's testimony is corroborated by Small World's telephone records, which showed a 13-minute call to Stoever's office on September 29, 1999 at 8:36 a.m.

Intake

Stoever called Illg after speaking with Roseberry and relayed Roseberry's concerns to him. She said Illg took her information and told her that he would call Roseberry. In an e-mail dated February 2000 to Heckenlively, Slawson and Illg, Stoever stated she called Illg "immediately" after speaking with Roseberry. [REDACTED]

However, he did not talk with Roseberry until the next morning. Clay County DHS Office telephone records show a 12-minute call to Small World at 8:49 a.m. on September 30, 1999.

Illg testified he considered Stoever's call an intake call, but he viewed Roseberry, not Stoever, as the reporter. He said he considered Stoever akin to a secretary in his office, responsible for taking down basic information and then passing it along to him, a CPW. He said his job is then to follow-up with the reporter, get additional information, and decide whether to accept or reject the report.

When questioned by the Ombudsman about why he waited to call Roseberry, Illg said he believed the DHS Manual gave him until the end of the next working day to notify the reporter whether the report is accepted or rejected for investigation. Illg said if Roseberry's allegations to Stoever would have caused him to suspect imminent danger to Shelby, he would have responded immediately and would not have waited until the following day to call Roseberry.

According to Illg’s testimony, Stoever told him about the grab marks on Shelby’s jaw. However, when he called Roseberry, she did not mention grab marks. He testified Roseberry told him substantially the following: Stoever must have misunderstood – she was not reporting abuse; she did not believe any of the injuries were inflicted; she knew the bruise and scrape on Shelby’s face was from her falling off the couch.

Roseberry remembered speaking with Illg about Shelby having a “four fingers and thumb print bruise on her face.... Just like somebody had grabbed her face, and like saying ‘Pay attention to me. I’m talking to you’.” Roseberry later described the injury as “...an adult hand cause we put our hand up on it and it was a thumb print and then.... Four fingers. Bruise. Deep bruise. Dark bruise. Perfect. Right on her jaw.” Roseberry said she never told Illg that she believed the handprint was not abuse, but she may have told him she did not think Watkins did it. Roseberry said Illg asked her to take photographs of the injuries and send them to him.⁵⁰

Stoever testified that Illg called her back on September 30, 1999 and told her Roseberry had completely changed her story - - that she no longer felt the injuries were abuse, and she believed Watkins’ explanation. In her notes, Stoever wrote, Roseberry “changed her story - going to send pictures.” She said Illg expressed frustration with Roseberry’s change of story.

Illg testified he rejected Roseberry’s report because she believed the injuries were accidental, and she did not suspect abuse. He did not believe he asked Roseberry to take photographs, because “that automatically becomes an investigation.”

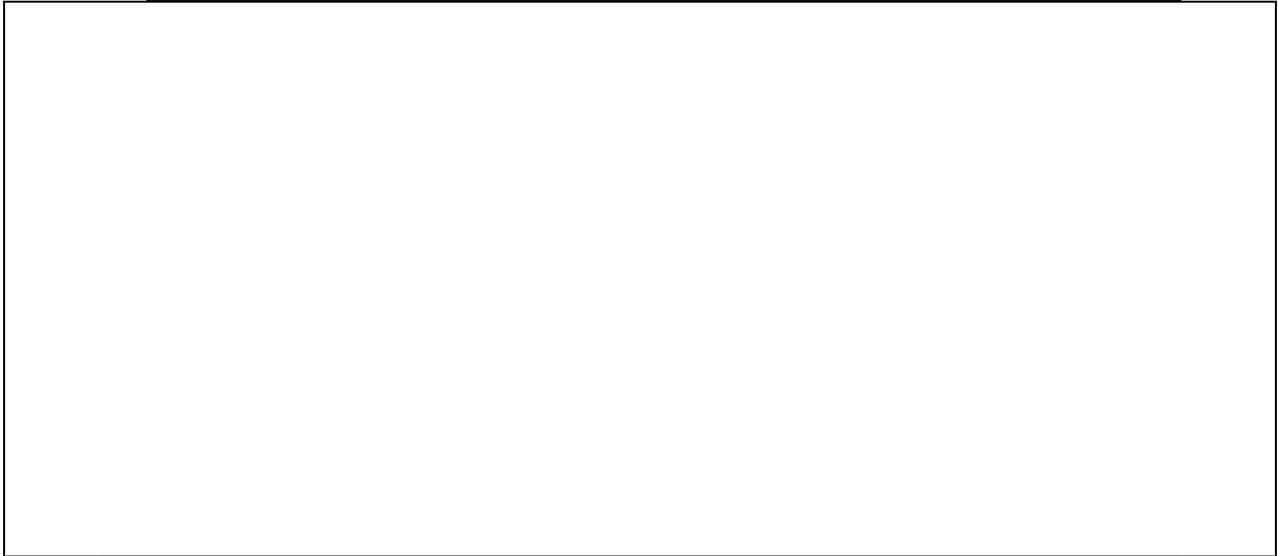
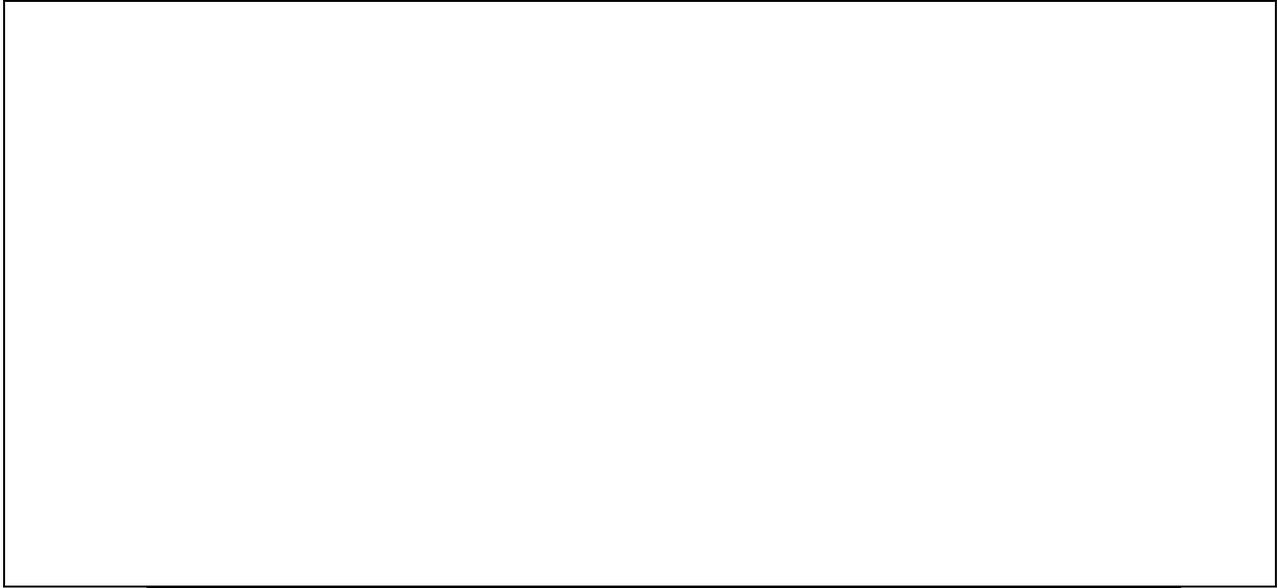
Illg said he did not document Roseberry’s report as a rejected intake on an Intake form. He acknowledged to the Ombudsman that he should have documented it as a rejected intake.

The Ombudsman finds, based upon witness testimony and Stoever’s contemporaneous notes, that Roseberry made a report of child abuse to Stoever as documented in her notes, and that Stoever in turn relayed the information to Illg. However, what was said in the conversation between Roseberry and Illg is in dispute. Since there is no evidence to corroborate either of their claims, the Ombudsman is unable to determine whether or not Roseberry’s report changed during intake, as Illg claimed.

Illg did not accept Roseberry’s report on the basis that she no longer suspected Shelby’s injury to be caused by abuse. It is not known if Illg told Roseberry of his decision. Illg did not complete an Intake form and document the report as a rejected intake.



⁵⁰ Roseberry testified she took photographs of Shelby’s injuries, but the prints turned out blurred.



October 21 – November 18, 1999 (Report, Intake, Assessment)

DHS received two separate reports of child abuse on October 21, 1999 regarding injuries on Shelby. The first report resulted in an assessment. While the assessment was ongoing, the second report was made regarding the same injuries. It is not known for certain what the intake worker did with the second report. The November 18, 1999 “Complete Assessment Summary, Parts A and B” (Assessment Summary)⁵¹ on the first report, made no reference to the second report.

Report from Karen Roseberry

Roseberry told the Ombudsman that Shelby said “ow”, as she was removing Shelby’s coat after Watkins had dropped her off the morning of October 21, 1999. Roseberry then noticed Shelby’s hand was “jet black. It was huge. I mean, it was so swollen.”

Roseberry testified she first tried to call Illg at home and was told he had already left for work. She then called his office, got through to his voice mail and left a message, saying that Shelby’s hand was swollen and asking him to call back immediately.

Roseberry next called Linn at home and asked her to come in right away. Linn testified that, when Roseberry called her at home before 8:00 a.m., she said that Shelby’s hand was all black and blue, and swollen and that she had already called DHS and left messages, one at Illg’s home and one at his office.

⁵¹ See Appendix G, *Child Protective Assessment Summary Part A; Child Protective Assessment Summary – Part B*. This is the version prepared by DHS for public release, with redactions of information that DHS believed to be confidential by law.

Roseberry said, when Illg did not call her back, she called his office two more times, was told by a female that Illg was not there, and was transferred to his voice mail. Each time she left a message on his voice mail saying to contact her about Shelby’s hand. Roseberry said she believed she had to call Illg because he was the worker who ended up responding whenever they made reports to DHS. She said, “I should have just taken her over there [to the hospital] myself, you know, but I wanted to prove a point. I wanted to show him that she was injured. I wanted him to do it.”⁵²

Small World’s long distance phone records are consistent with Roseberry’s account of when she called Illg’s home and office. The records show the following calls:

Date	Time	Minutes	From	To
10-21-99	7:31 a.m.	1	Small World	Illg’s home
10-21-99	7:32 a.m.	2	Small World	Clay County DHS
10-21-99	8:47 a.m.	2	Small World	Clay County DHS
10-21-99	10:26 a.m.	3	Small World	Clay County DHS

Intake on Karen Roseberry’s Report

Illg has a different account of when he received Roseberry’s report. In fact his testimony about what happened is at odds with what he stated in his Assessment Summary.

According to the Intake form completed by Illg, he received a report of “numerous suspicious injuries,” although he did not specify what the injuries were. The Intake form indicated he received the report at 11:00 a.m.

However, Illg later testified he actually spoke with Roseberry and did the intake between 7:00 and 7:30 a.m. He said he intentionally misstated in the Assessment Summary the times of the intake and observation of Shelby in order to protect the identity of the reporter.

According to Illg, Roseberry said Shelby was sleeping and when they pulled her coat off, she said, “Ouch.” Illg said she told him about the swollen hand and may have mentioned bruising on the back or a scratch on the ear.

Illg explained to the Ombudsman that he did not open an assessment when he first spoke with Roseberry, because there was no allegation a caretaker inflicted the injuries. He felt that he could still check out Shelby’s injuries, [redacted]

[redacted] It was after he saw Shelby that he determined her injuries were suspicious and investigatable. Illg said the injuries were suspicious because “there was a lot of them . . . obviously the thumb looked sore. Okay. The bruising on the back, the stubbed toe that was bloody, there was a scratch behind the ear, daycare was saying, no, we never got an explanation from Heidi.”

⁵² DHS administrative rules, 441-109.9(2) and 441-109.10(2), provide for licensed child care centers to have sufficient information and authorization to secure or meet the emergency medical and dental needs of a child while the child is under the center’s care.

The Ombudsman finds that Illg received a report of child abuse from Roseberry. The report alleged an injury to Shelby's hand serious enough to cause large swelling and pain, and possibly other injuries, including bruises on her back and a scratch on her ear, for which Watkins, the known caretaker, had offered no explanation to Roseberry.

Because Small World's telephone records and Linn's testimony are consistent with Roseberry's account, the Ombudsman believes Roseberry initially reported the information to Illg about 7:32 a.m. by leaving a message on his phone mail, and left two more messages that morning asking Illg to contact her.

Illg opened an assessment on the injuries.

Report from Dr. Tim Taylor

The second report of child abuse was made by Dr. Tim Taylor after Illg had opened an assessment. Dr. Taylor is one of the physicians with Lakes Family Practice.

Dr. Taylor examined Shelby between 5:00 and 6:00 p.m. on October 21, 1999. After the examination, including x-rays which revealed Shelby had a fractured metacarpal bone in her right hand, Dr. Taylor decided to admit her to the Hospital.

Dr. Taylor called DHS because he suspected abuse, either inflicted or caused by neglect. He spoke with the Hotline worker after his nurse dialed the number for him. He told the Ombudsman he believed the person who called him back that night was Illg.

Illg testified he did not remember speaking with Dr. Taylor on October 21, 1999. He said he recalled only one conversation with Dr. Taylor and that occurred on October 22, 1999.

Dr. Taylor said he thinks the telephones at Lakes Family Practice are connected to and sometimes roll over to the lines at the Hospital. ICN telephone records show the following call, which Dr. Taylor said could have been his call to the Hotline.

Date	Time	Minutes	From	To
10-21-99	6:59 p.m.	1.4	Hospital	Hotline

Margaret Monroe, the STS employee who took Hotline calls on October 21, 1999 from 4:30 to 7:30 p.m., told the Ombudsman the name Dr. Taylor "rings a bell." She said when doctors or police officers call, she usually just notes the date, time, name, and telephone number on the Contact Report form, and then pages the on-call worker.

Kerrie Morey was the on-call CPW for the Clay County Cluster that evening. ICN telephone records show a 0.8 minute call from Morey's home to the Hotline at 7:10 p.m.

Date	Time	Minutes	From	To
10-21-99	7:10 p.m.	0.8	Morey's home	Hotline

Clay County DHS telephone records indicate a five-minute “calling card” call was made from Morey’s home to Dr. Taylor’s home in Spirit Lake at 7:10 p.m.

Date	Time	Minutes	From	To
10-21-99	7:10 p.m.	5	Morey’s home	Dr. Taylor

The Ombudsman finds that Dr. Taylor made a report of child abuse concerning Shelby to the Hotline at 6:59 p.m. and that Morey got the page and called Dr. Taylor right away.

Intake on Dr. Taylor’s Report

The Ombudsman further finds that Morey, as the on-call CPW, handled the intake on Dr. Taylor’s call. The Ombudsman, however, did not find any evidence regarding what Morey did with Dr. Taylor’s report.

The Ombudsman finds that Dr. Taylor’s report was not documented on an Intake form. Even if the intake had been rejected, the form would still have been available when the Ombudsman requested those documents.⁵³ The Ombudsman also finds that Dr. Taylor’s report was not documented in Illg’s Assessment Summary regarding the same injuries.

Assessment – Determination Whether Abuse Occurred

- Observation of Shelby

Illg’s Assessment Summary stated he observed the following injuries:

Shelby has a very swollen thumb and wrist on her right hand . . . a scratch below [her] right ear . . . two red marks, which appeared to be bruises, underneath [her] right eye . . . several bruises, approximately the size of a dime and greenish in color, on [her] back . . . the fourth toe was covered in blood and looked very sore.

- Documentation - Photographs

Illg took 12 photographs of Shelby’s injuries on October 21, 1999.

From the photographs, the Ombudsman discerned the following visible skin discolorations and tissue swellings:

- Moderate localized swelling of the right upper hand specifically located in area of the right thumb and right index finger.
- Red to blackish blue discoloration between the right thumb and right index finger with reddish discoloration extending to the first knuckle of the right index finger.
- Small reddish discoloration on right cheek.
- Moderate in length, reddish discolored area located behind right earlobe.
- Small reddish circular discoloration under left eye.
- Large reddish discoloration over left cheek.

⁵³ A DHS spokesperson informed the Ombudsman that DHS found no rejected intakes concerning Shelby during its internal review in February 2000.

- Approximately ten to twelve scattered discolored areas extending from the middle to lower back. The discolored areas on the back ranged in size from small to medium with color ranging from yellow to greenish brown.
- Approximately six of the above-discolored areas were located over right lower portion of back.
- Slight to moderate swelling of fourth toe on left foot.
- Blackish blue discoloration on fourth toe of left foot covering the top portion of the toe extending downwards to include the nail bed.
- Two very small blackened areas on third toe of left foot.

In his Assessment Summary, Illg does not describe any discoloration on the hand, but when asked by the Ombudsman to review the photographs, he acknowledged they did show some discoloration.

- Interview at Small World

While he was at Small World, Illg interviewed Roseberry. Roseberry told him she and other Small World staff saw the swollen right hand and the scratch below the right ear that day; the marks beneath Shelby's right eye were apparent the previous morning; and the bruises on her back and injury to her toe were noticed two days before. Roseberry said Watkins offered no explanation for these injuries, although she questioned if the back bruises may be caused by other children trying to pick Shelby up. Roseberry told Illg none of the children were picking Shelby up, and none of the injuries occurred while Shelby was at Small World.

- Referral for Medical Examination

After observing Shelby and speaking with Small World staff, Illg tried to reach Watkins by telephone to get her to take Shelby to see a doctor. He did not reach Watkins until 3:40 p.m.

The Assessment Summary said he left messages for Watkins on three different answering machines. He testified he actually tried calling a couple of cell phone numbers Roseberry gave him, then left a message at Moritz Construction, where Watkins worked. His office telephone records show a three minute call was made at 3:40 p.m. to Moritz Construction.

Watkins' testimony at her trial confirmed she received a message, while at a job site, to call Illg around 3:30 p.m. She called him back right away. Illg told her to take Shelby to her family doctor or emergency room to have the swollen hand examined.

The Ombudsman finds that, when the conversation ended, Illg did not know if and where Watkins was taking Shelby for a medical examination, nor did he ask her to contact him with that information once she knew. The Ombudsman further finds he did not contact Dr. Taylor in advance of the doctor's examination of Shelby, to inform the doctor of what he knew about the injuries, including what Watkins told him - - that she did not know the existence of the injuries nor how they were caused.

Illg indicated in the Assessment Summary that, after he spoke with Watkins, he had contact with worker at the Dickinson County Memorial Hospital (Hospital).

Illg said [] told him Shelby was seen by Dr. Taylor and would be spending the night in the hospital.

However, information gathered by the Ombudsman casts doubt whether Illg spoke with [] on October 21, 1999. The Clay County DHS Office telephone statement shows no office or “calling card” call to the Hospital on October 21, 1999, but it does show a seven-minute call to the Hospital at 8:21 a.m. on October 22, 1999. Furthermore, [] entry to a Dickinson County Memorial Hospital record, “Discharge Planning Rounds/Consults,” on October 22, 1999 at 8:41 a.m., suggests that her first conversation with Illg had just occurred then.

[Received] call from Chuck Illg [at] DHS Protective [Services]. States an investigation is being done on this case. He will be here this a.m. to visit [with patient] and family. Family informed.

The Ombudsman believes Illg learned about Shelby being hospitalized from Morey, sometime after she spoke with Dr. Taylor on October 21, 1999.

- Cancellation of Home Visit

Immediately before he called [] the morning of October 22, 1999, Illg tried to reach Watkins at Moritz Construction. Clay County DHS Office telephone records show a one minute call to Moritz Construction at 8:19 a.m. The Ombudsman believes Illg was probably calling Watkins regarding his plans to meet with and interview her.

Illg had originally planned to meet with Watkins at her home. Watkins testified at her trial that Illg told her on October 21, 1999, “I want to meet with you tomorrow morning at 9 o’clock at your house.” Illg’s appointment book shows he had entered the name “Hiede” in the 9:00 a.m. time slot for October 22, 1999.

According to Watkins, those plans changed the morning of October 22, 1999.

That morning my mom had called me and asked me to come to the hospital and stay with Shelby so she could get some things done before I had to meet with Chuck, and I went up to hospital, and Chuck Illg was there at the hospital. And then we just met there at the hospital instead of going back to my house.

The Ombudsman finds Illg did not make a visit to Watkins’ home as part of this assessment, either to verify Watkins’ possible explanation for Shelby’s broken hand or to assess the home situation.

- Interview of Watkins and [] – Explanation for Injury

Illg interviewed Watkins at the Hospital about 10:00 a.m. on October 22, 1999. His Assessment Summary recounted what Watkins told him.

Heide stated that she does not know exactly what happened to Shelby’s hand...Heidi stated that the only thing she could think of is that on Wednesday night [October

20th]...Shelby started screaming. Heidi stated that she went in to Shelby's room and Shelby was out of her crib....

Heide stated to this worker that she did nothing to Shelby to cause her to break her wrist.

Heide stated she does not know how she got the scratch on her ear. Heide stated that Shelby is very active and that it could have happened a number of ways....

Heide stated that Shelby got a black eye over a week ago...Shelby went to jump off the bed and hit her head on the corner of the nightstand. Heide stated that the injuries underneath her eye are still from the black eye fading from that incident.... This worker then asked Heide about the bruises on Shelby's back. Heide stated that she did notice those bruises and was quite angry. Heide stated that she called Small World Day Care right away because she thinks that some of the younger kids are trying to pick Shelby up which could result in those bruises....

Heide stated she has had the injured toe for quite some time. Heide stated she does not exactly know how it happened the first time. Heide states that she thinks Shelby may have stubbed it ... the original injury is probably two weeks old ... Shelby keeps breaking it open because she runs around with no socks on.

Illg also interviewed [redacted] told him she had not noticed any of the injuries before she came to the hospital. She said Watkins was not abusing Shelby.

- Medical Consultation

After his interview of Watkins, Illg called Dr. Taylor from the Hospital and spoke with him regarding Shelby's injuries and the explanations given by Watkins. In his Assessment Summary, he stated the explanations they received from Watkins matched. He wrote:

Dr. Taylor stated that he does not feel any of the injuries were inflicted. Dr. Taylor stated that a fall out of the crib certainly could have caused Shelby to break her wrist. Dr. Taylor stated that the scratch below her ear is minor and that could have happened any number of ways. Dr. Taylor stated that the bruises on Shelby's back are isolated and do not form a pattern. Dr. Taylor stated that he does not know how Shelby received the bruising to her back but, due to the fact that there is no pattern, it suggests that the injuries were likely to be accidental rather than inflicted. Dr. Taylor stated that the injuries underneath Shelby's eyes could be the result of Shelby's black eye healing. Finally, Dr. Taylor stated that Shelby's toe could be the result of an injury by hitting the toe or stubbing the toe.

According to Illg, even though Dr. Taylor did not think any of the injuries were inflicted, the doctor had concerns about Watkins' response to the toe and wrist injuries.

Dr. Taylor stated that there probably needed to be better medical care of the toe so that it would have healed much faster . . . Dr. Taylor stated . . . he was concerned that the injury to Shelby's wrist was not addressed sooner. Dr. Taylor stated that

the wrist was bruised and was blue in color. Dr. Taylor stated that the injury had been there at least 24 hours and should have been detected earlier.

The Ombudsman notes that, throughout the Assessment Summary, Illg referenced Shelby's injury as a "broken wrist." Illg said he believed Dr. Taylor referred to it as a wrist injury. However, Dr. Taylor's progress notes of October 21, 1999 indicated the injury was a "fractured 1st metacarpal." There is no mention of the word "wrist."

The Ombudsman finds that Illg misidentified the fractured metacarpal on Shelby's hand as a "broken wrist" in the Assessment Summary.

The Ombudsman further finds that Illg did not request a copy of Shelby's medical records from Dr. Taylor (Lakes Family Practice) or the Hospital.

Assessment – Evaluation of Home Environment and Family Functioning

Illg mentioned he had renewed concerns about Watkins' honesty about her drug usage. He noted that one of Watkins' close friends is a "known drug user and has been incarcerated because of drug use." Otherwise, Part B is essentially identical to Part B of his March 23, 1999 Assessment Summary. As mentioned earlier, Illg did not do a home visit as part of this assessment.

The Ombudsman again finds that there is very little updated or new information in the Assessment Summary concerning the home environment and family situation.

Determination and Recommendation

Illg determined the report of physical abuse was unconfirmed, based on the finding that the injuries appeared to be accidental, and not the result of any acts or omissions by Watkins.

However, in consideration of Dr. Taylor's concerns and Watkins' history - - six investigations, three founded reports - - Illg recommended voluntary in-home services and random drug tests, to which Watkins agreed. Illg noted "ongoing concerns about Heidi's drug use and how that affects her supervision of the children" as a factor in his recommendation.

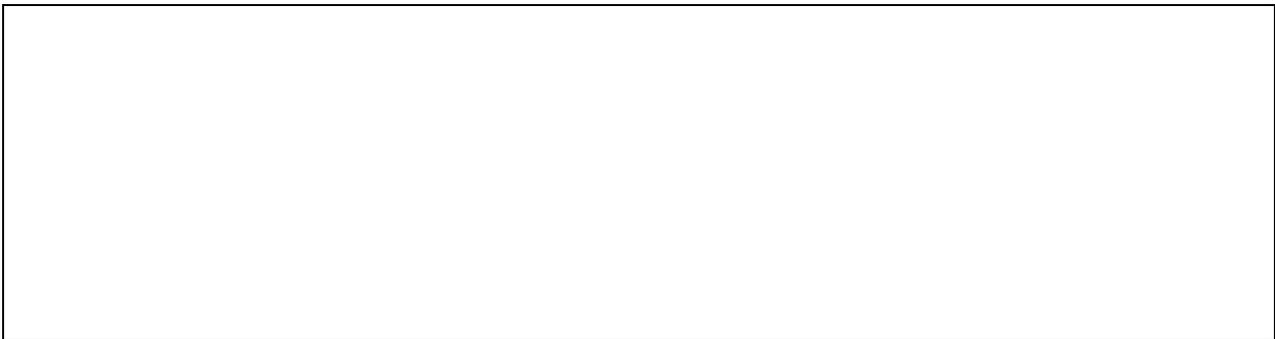
There was no recommendation for juvenile court involvement nor any criminal referral to the Spirit Lake Police Department. Slawson, Illg's supervisor, approved the Assessment Summary.

The Ombudsman finds that, although Watkins agreed to accept in-home services on October 22, 1999, Illg did not get her to sign an "Application for Social Services" form at that time. Illg said he did not have the form with him. He left that responsibility up to the Case Manager to handle.

November 1999

Phyllis Slawson assigned a service case on and Shelby to Case Manager Deb Nelson on November 4, 1999. Nelson's role was to secure or arrange the services that had been recommended, and to monitor the services and the progress of the family.

On November 8, 1999, Nelson asked Illg for Watkins' telephone number and address. Illg gave Nelson the address and the telephone number for Moritz Construction, saying the best place to reach Watkins was at her place of employment.



December 2, 1999 – January 4, 2000 (Report, Intake, Assessment)

The last report concerning Shelby that resulted in an assessment before her death was made on December 2, 1999. The Complete Assessment Summary, Parts A and B (Assessment Summary)⁵⁴ was dictated by Illg on December 13, 1999. However, it was not approved by Slawson, his supervisor, as being completed until January 4, 2000.

Report

Deb Gosch received three calls between November and December 21, 1999 from an informant who wished to remain confidential. That informant had concerns about Shelby but did not want to report them to DHS herself. Gosch believed she called Illg about the concerns each time she heard from the informant, but was uncertain of the dates and all the concerns she told Illg.

Gosch did recall specifically reporting to Illg about bruises on Shelby's face and burns on her stomach. However, the Ombudsman is unable to find that Gosch made any other reports of child abuse to DHS, given her uncertainty and no supporting documentation.

Intake

According to the Intake form completed by Illg, he received a report at 9:30 a.m. on December 2, 1999. The allegation on the form stated:

Reporter states that Shelby has a cigarette burn on her stomach. Reporter also states that Shelby has bruising on her face and a possible broken nose.

After conducting the intake, Illg accepted the report. The case was assigned to him to complete the assessment.

⁵⁴ See Appendix H, *Child Protective Assessment Summary Part A; Child Protective Assessment Summary – Part B*. This is the version prepared by DHS for public release, with redactions of information that DHS believed to be confidential by law.

Assessment – Determination if Abuse Occurred

Illg's Assessment Summary stated that he first tried calling [redacted], because she was providing daycare for Shelby. After five attempts, he reached her at work at 2:40 p.m. He told her what had been reported.

According to the Assessment Summary, [redacted] told Illg that Shelby did not have a cigarette burn and "the injury on Shelby's stomach was inflicted by Shelby." She also said Shelby's "eyes were discolored" because she fell and hit a box at [redacted] home.

[redacted] informed Illg that Watkins had the day off and Shelby was at Watkins' home. Illg stated he was unable to make contact with Watkins that day.

Illg met with [redacted] and Watkins at [redacted]' home the next day at 10:30 a.m. At his invitation, Nelson also went to the home. Nelson told the Ombudsman she accompanied Illg because "that's something we've kind of started to do. It's a transition from the child protective workers to the case managers, so we can meet the family."

- Observation of Shelby

According to his Assessment Summary, Illg observed a "very small injury on Shelby's stomach but it looked like a carpet burn. It, in no way, looked like Shelby had been burned with a cigarette."

He also said in the Assessment Summary that Shelby had "two black eyes that faded very quickly." When asked by the Ombudsman what he meant, Illg said:

When I dictated this up I thought that maybe her eyes were worse and that was the fading that they were going away.

Illg testified that the discoloration was "not black" in color and "it wasn't all that discolored." He also described the discoloration was located underneath her eyes.

Illg also told the Ombudsman that Shelby had a bruise that was a "quarter to a half inch, more like a quarter ... above the eyebrows, above the bridge of the nose." However, the Ombudsman notes there is no description of any bruise on Shelby's forehead in his Assessment Summary.

Nelson testified she saw what appeared to be a scrape on Shelby's stomach, "light red in color, 1 ½" wide and maybe 2" long, right in the center of her tummy, right above her tummy - her belly button." She said, "The injury on her stomach was definitely not a cigarette burn." She also testified that Shelby had two black eyes. "Her eyes were black and across the bridge of her nose was black." She said she did not notice any bruise or mark on Shelby's forehead.

Two other individuals who testified they saw Shelby the afternoon she allegedly hit the box corroborated Illg's belief that the bruising was "fading" or "going away." One said, "The bruises around her eyes were already turning yellow." The other said she saw "an old bruise and it was all yellow on her nose."

The Ombudsman finds that, at the time Illg observed Shelby on December 3, 1999, he saw bruising underneath both eyes that was no longer black in color. The Ombudsman further finds that it was Illg's impression, at that time and also when he dictated the Assessment Summary on December 13, 1999, that the bruising was fading and going away.

- Documentation - Photographs

The Ombudsman finds Illg did not take any photographs of Shelby's injuries. Illg said he forgot to take the camera.

- Interviews – Explanation for Injury

Illg interviewed [] and Watkins about how Shelby's injuries occurred. His Assessment Summary included the following explanations from them:

Both Heide and [] stated that Shelby had her cast on her arm from her broken wrist, which happened around October 21st. Both Heide and [] stated that Shelby would scratch her stomach with the cast....

[] stated that she and Shelby were folding clothes in the laundry room.
[] stated that she stomped her feet to act like she was going to chase Shelby.
[] stated that Shelby took off running, tripped over a plastic bag which had Christmas items in it, and fell on to a Fisher Price box.

Illg stated he had “an opportunity to speak with []” and “[] had no explanation for the injuries.”

[] told Illg, in the afternoon after Shelby hit her head, she had taken Shelby to the home of her [], for [] to watch Shelby.

The Ombudsman finds Illg did not interview [] to find out what she observed and knew about Shelby.

Verification – Explanation for Injury

Illg did go to [] home, the site where Shelby allegedly tripped and fell against a box containing a toy. His Assessment Summary indicated [] laid out where the box and plastic bag were.

Illg told the Ombudsman he did not lift or examine the box closely. He said he “assumed it was a packed box.” He did not recall “seeing any dents on the corners or any of the corners pushed down.”

Assessment – Evaluation of Home Environment and Family Functioning

As in the two previous assessments, the Ombudsman finds that the discussion in Part B of the Assessment Summary concerning the home environment and family functioning is virtually a restatement of the Assessment Summary Illg completed on March 22, 1999.

The Ombudsman further finds there was no visit to Watkins' home as part of his assessment regarding the home environment and family functioning.

Determination and Recommendation

Illg was satisfied with the explanations given for the injury on Shelby's stomach and the bruising around her eyes, and concluded the injuries were accidental. He determined the report of physical abuse to be "unfounded."

As for recommendations, Illg noted that he had "made a recommendation for services" to be provided by DHS and that Watkins had "agreed to voluntarily work with in home services." However, there is no mention of Watkins agreeing to random drug tests.

The Ombudsman finds that Illg did not reference or reiterate his recommendation and Watkins' agreement to undergo random drug tests, as previously stated in his November 18, 1999 Assessment Summary.

Although Illg did not recommend juvenile court action in the Assessment Summary, he noted he would consider a Child in Need of Assistance action for Shelby and [] "in the event that Heidi does not keep scheduled appointments" for services. Slawson, Illg's supervisor, approved the Assessment Summary.



December 12, 1999

Report from Sherry Dawson

On December 12, 1999 Sherry Dawson called a paramedic at the Dickinson County Memorial Hospital (Hospital) and then called the Hotline three times about Shelby.

Dawson first met Watkins, Shelby, and [] through a mutual friend in late October 1999. From then until Shelby's death, Dawson regularly visited Watkins and her children at Watkins' home.

During a visit the evening of December 12, 1999, she saw Shelby lying motionless on the floor with her diaper undone. She observed Shelby had a contusion in the middle of her forehead, swollen nose and face, two black eyes, and bruises and burns in her vaginal area, and what she believed were cigarette burns on her inner thighs.

Watkins told her the vaginal area injuries were reactions from fingernail polish that Shelby had chewed off and from Febreze (a fabric deodorizer) that she had put on Shelby's bunk bed.

Dawson left Watkins' house, went home, and talked with her sister, mother, and a friend about what she had seen. Her sister suggested she call DHS.

Dawson then called a paramedic, Chris Yungbluth, at the Dickinson County Memorial Hospital. She told him about the injuries she had seen on Shelby, although she did not identify Shelby by name. However, Yungbluth did not remember Dawson mentioning any vaginal sores and whether they may be a reaction to fingernail polish or Febreze.

Yungbluth got Dawson's first name and telephone number and told her he would call DHS and leave a message for someone to call her. Dawson testified he also gave her the Hotline number so she could also call. Yungbluth believed Dawson indicated she already had tried calling that number and it was busy.

Dawson called the Hotline after talking with the paramedic and described the injuries she saw to the Hotline worker. She testified that she identified "Jesse" as the suspected abuser and also told the Hotline worker that Jesse was living in the home during that call.

The information Dawson reported was recorded by Chris Christensen, the Hotline worker, on a "Contact Report" form. According to Christensen's "Contact Report," Dawson identified the child as Shelby, last name unknown; she reported physical abuse, sexual abuse, and denial of critical care or neglect; she identified the parent as Watkins and the suspected abuser as Jesse, last name unknown; she said Jesse lived with Watkins; she described the abuse as two black eyes and facial contusions, bruising and open sores on genitalia, bruising on legs and stomach, possible concussion.⁵⁵

ICN telephone records show the following call detail from Dawson to the Hotline.

Date	Time	Minutes	From	To
12-12-99	9:32 p.m.	6.9	Dawson	Hotline

Christensen told Dawson he would page the on-call worker. Christensen then paged Kerrie Morey, the CPW from the Spencer Cluster who was the on-call worker that night.

According to Christensen, while waiting for Morey's return call, an "ER nurse" named Chris [Yungbluth] at the Hospital called the Hotline. He said Yungbluth gave him Dawson's first name and telephone number and asked that someone contact her about information she had concerning a child. Christensen told Yungbluth he had just received a call from her and already had her information. Christensen said the notation "ER is Calling Back" on the "Contact Report" was to indicate that Yungbluth was going to call Dawson Back.

Telephone records substantiate that Morey called Christensen shortly after he spoke with Dawson. However, those records indicate that Morey called Christensen back before he received

⁵⁵ See Appendix I, *Child Dependent Adult Protective Investigations Contact Report*, completed by Chris Christensen on December 12, 1999.

Yungbluth's call from the Hospital.

Date	Time	Minutes	From	To
12-12-99	9:42 p.m.	3.4	Morey's home	Hotline
12-12-99	9:46 p.m.	0.9	Hospital	Hotline

Christensen testified that when Morey called back, he read to her all the information that he had documented from Dawson on the Contact Report. He said the large notation "Ref" meant that he had referred the report to the on-call CPW.

ICN telephone records match Christensen's testimony that Morey called him after a page.

Date	Time	Minutes	From	To
12-12-99	9:42 p.m.	3.4	Morey's home	Hotline

Morey testified she had no recollection of having received a page from the Hotline worker nor having called the Hotline and receiving information related to Dawson's report. She said when she is on-call and receives a Hotline report, she follows a "ritual," which includes writing down the information in a notebook and calling the reporter immediately. She said, "There would never be a time I would not call the reporter."

Morey said in instances when she could not reach the reporter right away, depending upon the seriousness of the information, she might wait until the following morning to call the reporter. After seeing Christensen's "Contact Report," Morey said that would be an instance where she would not wait. If she could not reach the reporter, she would have called her supervisor for direction on what to do and the Spirit Lake Police to go check on Shelby right away.

I would have went out on that because you don't get bruises on your genital area. And I think the word, "possible concussion" was there, that would have been another thing I would have went out on.

Dawson testified that she was home that evening and did not receive any call from the DHS on-call worker. She said she was expecting the call and would have been alerted to any calls that came in while she was on the telephone, since she had call-waiting.

Neither Clay County DHS Office long-distance telephone records (office and calling card) nor Morey's home telephone records show any call to Dawson's home on December 12, 1999.

DHS does not have any documentation of Morey's receipt of the Hotline report or what she did in response to the report, including any completed intake form.

Dawson called the Hotline two additional times that evening. She provided additional information in her second and third calls. In her second call, she said she gave the Hotline worker more information about the contusion to Shelby's head and the "altered" swelling.

[W]hen I called back I let him know that Heidi had let me know that this had happened. The contusion to her head had happened three days prior, and that she

had been working and been rocking with her, and holding her and so on – so forth. Staying home with her because of the fact that the swelling had altered.

In her third call, Dawson said she told the Hotline worker more about Jesse being alone with Watkins’ children.

[W]hen I called the third time I think I may have filled him in more about the fact that, that she was left alone with the boyfriend repeatedly . . . and that he was the caregiver on numerous occasions.

Christensen recalled only receiving the one call from Dawson - - the one he documented on the “Contact Report.” He testified if a reporter called with additional information, he would note the time and information on the “Contact Report” and re-page the on-call CPW to relay the information. He said if other staff handled the other calls from Dawson while he took a break, they would have completed Contact Report forms and/or discussed those calls with him upon his return. He did not remember any such discussion.

Christensen said, at the end of his shift, he noted on a log sheet the hours he worked, the number of calls received, and the number of calls that were referred to the on-call worker. For December 12, 1999, Christensen logged four calls and one referral, which correlated with telephone records of the number of calls and the persons who had called -- three calls from Dawson and the one call from Yungbluth.

ICN telephone records corroborate that Dawson made two additional calls to the Hotline.

Date	Time	Minutes	From	To
12-12-99	10:15 p.m.	2.9	Dawson	Hotline
12-12-99	11:04 p.m.	3.6	Dawson	Hotline

The Ombudsman finds that Dawson made three calls to the Hotline on December 12, 1999. In the first call, she made a report of child abuse to the Hotline, as documented by Christensen, the Hotline worker, on a “Contact Report.”

After Christensen paged Morey, she called him and he relayed Dawson’s report as he had documented on the “Contact Report,” including the description of the injuries, and information that someone named “Jessie” was the suspected abuser and that he was living at Watkins’ home.

Immediately after his conversation with Morey, Christensen received a call from Yungbluth, a paramedic. Yungbluth told him about receiving a call from Dawson, and Christensen determined she was the same reporter that he had just spoken with.

The Ombudsman further finds that Morey did not call Dawson back to complete an intake on the report, nor did she document the call on any Intake form.

December 13 – 22, 1999

Intake on Sherry Dawson's Report and Ensuing Contacts

Following her report of child abuse to the Hotline, there were nine telephone exchanges between Dawson and staff at the Clay County DHS Office from December 13 to 22, 1999. The Ombudsman discovered a number of factual disputes and discrepancies among the witnesses regarding these calls - - who talked to whom, when, and what was discussed.

- Summary of Dawson's Testimony

Dawson's recollection is that, since no one had contacted her about the report she made to the Hotline, she again called the Hotline the following morning (December 13, 1999). She was transferred to the Clay County DHS Office, left a message, and then Illg called her.

She was certain the first person she spoke with that day concerning Shelby was Illg. She did not know Illg's name before then. Her most specific recollection is that she spoke with Illg a total of five times.

Dawson testified that in her first conversation with Illg, she described the injuries she had seen on Shelby:

[B]oth of her eyes were just black She had a contusion in the middle of her forehead ... the whole center of her head right here was swollen...[O]n her mound was bruising, discoloration ... cigarette burn marks on her legs and on her vaginal lips and ... her inner thighs.

She said in explaining the burn marks to Illg, the "only thing I could compare them to ... was a bad case of bedsores on a neglected geriatric patient."

She said she also identified Jesse as Watkins' live-in boyfriend and the suspected abuser.

The first phone call I explained to him that this child, from what I could tell, had been sexually molested. That Jesse was in the home. I didn't know the last name at the time. I just said the boyfriend Jesse was living there. She was left alone a lot with Jesse, and I didn't know anything else about the man.

Dawson estimated her first conversation with Illg lasted about "20 minutes or more." She said that she explained Shelby's injuries in detail and that Illg "listened attentively and acted like he was very concerned." She said Illg told her he "had quite a few complaints" regarding Shelby and was "looking into these matters." She said he indicated he would contact Watkins regarding taking Shelby to the doctor. She said Illg did not have Watkins' home telephone number, so she gave it to him.

In response to the Ombudsman's question if Illg asked about Shelby's injuries, Dawson replied,

Not really, no, I don't recall him asking me any questions at all about it cause I'd explained it to him already in detail enough and he just wanted to get off the phone with me....

He was too quick to go, 'oh yeah, O.K.,' the immediate response, 'oh yes we'll take care of that. We'll get right on that definitely, yeah it's terrible.'

Dawson said she called Illg again later that day and was told he would be out of the office until 3:00 p.m. She reached Illg after 3:00 p.m. and asked what he was doing for Shelby. She said she spoke with him for "10 minutes maybe." According to Dawson, Illg said he had not been able to reach Watkins but he was going to ask Watkins to take Shelby to the doctor for an examination.

Dawson also testified that in a subsequent call that week, she told Illg that Shelby's "face was black again" and she wanted to know what he had done.

She said she "blew up" at him in the next to last call with him, and Illg told her, "I've been doing my job for so long, don't you think that I can do my job better than you," and she hung up.

In the last call with him, she said he told her "his investigation was done, that he had passed it on to [a] caseworker in Spirit Lake and if I had any additional information that I could speak with her."

Dawson recalled having a discussion with Illg about a friend seeing drugs being used at Watkins' home. She said Illg asked her to have someone who witnessed it to call him.

She said that he also asked her to go into the home and "take pictures of Shelby."

Dawson said in one call, she ended up speaking with a female because Illg was not in the office. Dawson said the woman "peeved" her because she wanted to tell the woman more information, but the woman would not listen and instead said she could not tell Dawson any information. She said that call may have occurred on the same day following her first conversation with Illg.

Dawson also recalled calling and speaking with Slawson, Illg's supervisor, towards the end of December. She said she made this call after she became angry with Illg, and he told her to talk to his supervisor if she had a problem with what he was doing. She said the supervisor told her Illg "was doing his job." In subsequent testimony, Dawson said that she was put in touch with someone whom she believed was Slawson, who told her that her concerns would be looked into.

- Summary of Illg's Testimony

Illg testified he spoke with Dawson on three occasions before Shelby's death and each time was on a different day. He remembered calling her only once and the other times she called him.

According to Illg, in his first conversation with Dawson, she reported a bruise on Shelby's forehead and black eyes or discoloration of her eyes. He said she told him she saw the injuries "last night or the other day." He said he asked Dawson several questions to find out more information, but she did not want to get involved.

He testified he did not believe Dawson's report should have been treated as an intake.

She was reporting something that I believe had already been opened for investigation or at least had been addressed in an investigation. And it wouldn't have been opened as a new intake, but should have been included in the report -- the 12-2-99 report.... [T]he injury matched what ... the injury seen on the 3rd of December.

However, Illg acknowledged to the Ombudsman that the bruising Dawson reported to him was "discolored more."

Illg believed the second conversation with Dawson concerned Watkins' boyfriend using drugs in her home. Illg said Dawson indicated she got the information from a friend. Illg denied that Dawson ever identified someone named "Jesse" as Watkins' boyfriend or that he lived at the home.

I asked her . . . who is he, does he live there, what kind of drugs is he using, is he using it in front of the kids. And Sherry's response was, 'Well, this is what a friend told me.' . . . I even asked her if he was living in the home, and she wouldn't answer or she didn't answer.

Illg said he made several efforts to elicit the identity of Dawson's friend and encouraged her to have the informant call anonymously.

Illg said he did not consider Dawson's call regarding alleged drug use as an intake then.

The allegation was drug use in the home but no allegation of what type of drug, whether it was being used in front of the children, whether the children were even at home when it was being used, whether there was caretaker status.

Illg also recalled Dawson reporting redness and sores in Shelby's vaginal area in a subsequent conversation. He said that conversation took place after he called Dawson back after Morey took a message for him from Dawson. He said that was either his second or third conversation with Dawson.

Illg said Dawson's concerns about the redness and sores in Shelby's genital area were not investigatable because "there was no specific allegation -- she reported it as a diaper rash." When questioned further by the Ombudsman if Dawson actually said the words "diaper rash, " Illg replied:

I think she may have said . . . it's like a diaper rash. It's red. It's sore. It has sores, something like that.

Illg did not mention Dawson reporting any swelling to Shelby's face in his initial account to the Ombudsman regarding her calls. Later in his testimony, the Ombudsman pointed out a letter from him to Watkins dated December 29, 1999, in which he mentioned he had

received concerns that “Shelby’s eyes and face were swollen.” Illg then acknowledged that those concerns came from Dawson.

Illg testified he did not inform Dawson whether he was accepting or rejecting her report for assessment. Illg said that, since Dawson was just a permissive reporter, he could not tell her that he had already received the same report and was investigating it because that would be breaking confidentiality.

- Summary of Morey’s Testimony

Morey testified that she only spoke with Dawson once and, when she did, she got the impression Dawson had already spoken to Illg. When Dawson called, a secretary either transferred Dawson’s call or gave her a message to call Dawson, because Illg was out of the office.

Morey testified Dawson alleged that Shelby had been sexually abused and mentioned “redness on the inner thigh and the black eye....” She said when she replied that redness on the inner thigh, by itself, is not sexual abuse, Dawson became very upset.

Sherry was very upset because I explained to her that we could not open a sexual abuse investigation unless we had an allegation of someone touching the child or, you know, some injury in the vaginal area that suggested sexual abuse....

She could have told me vaginal area. I just recall the inner thigh area. Redness in the vaginal and the inner thigh area itself is not sexual abuse. And I specifically asked her if she had any additional information, or if she knew of anything that would lead her to think that it was sexual abuse. What she was describing to me was a diaper rash.

Morey testified that she initially handled the call as an intake, but did not document it as an intake because Illg had already opened an assessment concerning Shelby. Morey said Dawson told her midway through their conversation that Illg “had an open investigation,” so she stopped completing the Intake form and took notes instead. She said after the conversation, she checked Illg’s case log in his office and found he had a current assessment. In later testimony Morey said she put Dawson on hold and checked Illg’s case log. She subsequently told Illg of Dawson’s call and gave him her notes.

- Summary of Slawson’s Testimony

Slawson told the Ombudsman that she did not talk with Dawson or receive any phone messages from Dawson in December 1999.

Slawson said she was unavailable to take Dawson’s call—she was working at another county office on December 15, 1999 and was on vacation December 20, 1999 to December 23, 1999.

Telephone Records and Subsequent Testimony

After the Ombudsman obtained Dawson’s and the Clay County DHS Office’s telephone records, the Ombudsman reinterviewed Dawson, Illg, and Morey. The Ombudsman compiled the following call details from the telephone records. The records reveal nine telephone exchanges

from December 13 to December 22, 1999 between that Office and Dawson. All the calls from Dawson were made initially to the Hotline and then transferred to the Office.

Date	Time	Minutes	From	To
12-13-99	9:46 a.m.	13.0	Clay County DHS	Dawson
12-13-99	10:26 a.m.	2.8	Dawson	Hotline/Clay County DHS
12-13-99	2:11 p.m.	1.5	Dawson	Hotline/Clay County DHS
12-13-99	3:49 p.m.	0.6	Dawson	Hotline/Clay County DHS
12-13-99	4:13 p.m.	9.0	Clay County DHS	Dawson
12-15-99	11:22 a.m.	6.8	Dawson	Hotline/Clay County DHS
12-15-99	2:29 p.m.	3.0	Clay County DHS	Dawson
12-22-99	10:53 a.m.	9.6	Dawson	Hotline/Clay County DHS
12-22-99	11:09 a.m.	2.5	Dawson	Hotline/Clay County DHS

The Ombudsman pointed out to Dawson that the telephone records did not indicate she initiated the first call with DHS on December 13, 1999. Dawson still believed she called the Clay County DHS Office through the Hotline, left a message, and then Illg called her back

When presented with the Ombudsman's compilation of the telephone calls between his Office and Dawson, Illg said the first call at 9:46 a.m. on December 13, 1999 could not be his.

Illg testified he could not have made that call because he had left work before 10:00 a.m. to attend his son's Christmas program at a preschool ten blocks away. He said he arrived at the preschool early, five to ten minutes before the 10:00 program was to begin. He said the trip to the preschool takes several minutes. He said in order for him to arrive five minutes early, he must have left the office at 9:50 or before.

At the Ombudsman's request, Illg provided a copy of the December 1999 pages from his appointment book, which he had in his possession. His appointment book showed an entry for his son's program at 10:00 a.m. on December 13, 1999. He testified his normal practice is to enter the appointment at the scheduled time. However, his official timesheet for that day showed that he worked until 10:00 a.m., and then resumed work at 11:00 a.m. Illg acknowledged his timesheet showed when he began or ended work in 15-minute intervals.

The preschool teacher told the Ombudsman the Christmas program was scheduled to begin at 10:15 a.m., not 10:00 a.m. She remembered seeing Illg and his wife in the audience when she brought the children into the room to begin the program right at 10:15 a.m. She said she had no idea exactly when Illg arrived.

When the Ombudsman pointed out to Illg the discrepancy in the program's start time, Illg acknowledged it was physically possible for him to make that call to Dawson, but still contended that he "did not make that call."

Illg said he went to an appointment in Spirit Lake after his son's program. He believed the 4:13 p.m. call was from him to Dawson, after which he called Watkins to take Shelby to the doctor.

Illg's appointment calendar indicated he had an appointment away from the office at 11:00 a.m. on December 15, 1999. It is his belief that he did not take the 11:22 a.m. call from Dawson. He

said it was possible that Morey took that call. He believed the 2:29 p.m. call to Dawson was from him, after which he again called Watkins.

Morey said her one-time conversation with Dawson was shorter than the thirteen-minute call to Dawson at 9:46 a.m. on December 13, 1999, but longer than the 1.5 and 0.6 minute calls from Dawson at 2:11 and 3:49 p.m. She said she started her workday at 8:00 a.m., left the office at 11:00 for a noon appointment out-of-town, and returned to the office between 2:30 and 3:00 p.m. She did not believe the nine-minute call to Dawson at 4:13 p.m. was hers because she remembered speaking with Dawson earlier in the day.

Morey said she was in the office on December 15, 1999 and could have taken Dawson's 11:22 a.m. call.

As for December 22, 1999, Illg told the Ombudsman that he attended a meeting in Spirit Lake at 9:00 a.m. but may have returned in time to take both calls from Dawson.

Illg told the Ombudsman he did not remember what his last conversation with Dawson, prior to Shelby's death, was about. In his January 5, 2000 memo to Heckenlively Illg relates Dawson telling him, in one of his last two calls with her, that if Shelby died, "it would be on his shoulders." He recalled telling Dawson that, "[I] knew how to do my job better than she did just like she knew how to do her job better than I would."

The Ombudsman finds that, in the nine telephone calls between Dawson and the Clay County DHS Office, she spoke with Illg five times and with Morey one time regarding Shelby. More specifically:

- *The Ombudsman finds that on December 13, 1999, Illg spoke with Dawson twice and completed an intake on the report that Dawson made the previous evening to the Hotline. Illg made the first call to Dawson at 9:46 a.m. Dawson tried to call Illg three more times that day to give him more information and to find out what he was doing for Shelby. Dawson left messages because Illg was not in the office. Illg then called Dawson back at 4:13 p.m.*
 - o *Testimony from Dawson, Illg, and Morey point to Illg, not Morey, as the first CPW to speak with Dawson. All three believed that the one time Dawson spoke with Morey occurred after Illg first spoke with Dawson.*
 - o *Illg was in his office when the 9:46 a.m. call was made and had the opportunity to complete the call before leaving the office in time to attend his son's Christmas program.*
 - o *Dawson's impression that Illg "just wanted to get off the phone with me" is consistent with Illg wanting to get to his son's Christmas program, scheduled to begin at 10:15 a.m.*

The Ombudsman believes the logical inference is that Illg somehow learned about Dawson's December 12, 1999 call to the Hotline from Morey and followed up on it by calling Dawson the morning of December 13, 1999.

- *The Ombudsman finds that on December 13, 1999, Dawson reported to Illg the following injuries on Shelby: two black eyes, bruise or contusion on forehead, swollen eyes and face, and sores and redness in the vaginal area.*

Furthermore, the Ombudsman finds that Dawson reported that she believed the vaginal sores and redness were due to sexual abuse and that she did not ascribe the cause to "diaper rash." The Ombudsman believes that Illg and Morey inferred that what Dawson was describing -- sores and redness -- was diaper rash.

The Ombudsman finds Illg had received all of this information by the end of his last call with Dawson on December 13, 1999.

Given conflicting testimony, the Ombudsman is unable to find that Illg understood from Dawson that she suspected Watkins' boyfriend, named "Jesse," as the abuser and that Jesse resided in Watkins' home.

- *The Ombudsman finds that Illg did not accept Dawson's report on December 13, 1999 for assessment, and that he handled her report as an undocumented rejected intake. The Ombudsman further finds that Illg did not inform Dawson that her report was being rejected and the specific reason for the rejection.*
- *The Ombudsman further finds that Illg had three subsequent conversations with Dawson -- one in the afternoon of December 15, 1999, and two in the morning of December 22, 1999 -- in which Dawson reiterated her concerns. Dawson also tried to find out what action Illg was taking with respect to Shelby, and expressed frustration that nothing had been done, including getting Shelby to see a doctor. In the first conversation on December 22, 1999, Dawson became angry with Illg, and he informed her she could contact his supervisor. In the second conversation on December 22, 1999, Illg informed her he was finished with his investigation. The Ombudsman also finds Illg did not document any of these contacts.*

Because of conflicting testimony and for the same reasons stated previously, the Ombudsman is unable to substantiate that Dawson also reported new bruises around Shelby's eyes -- "an injury on top of an old injury" -- in one of her subsequent calls.

- *The Ombudsman further finds that Morey took a call from Dawson to Illg the morning of December 15, 1999, and advised him of the call after he returned to the office.*
- *The Ombudsman, however, is unable to find that Dawson spoke with Slawson as she believed she did. Slawson was not in the office during the days or times when Dawson called. The Ombudsman believes Dawson may have tried to call Slawson right after her she became angry with Illg on December 22, 1999; however, when Dawson found out Slawson was not available, she ended up speaking with Illg again.*

December 13 – 17, 1999

DHS Contacts with Heidi Watkins

Even though he did not consider what Dawson reported to be investigable, Illg said he believed he could legally call Watkins, because he still had an open case on Shelby. He said the December 2, 1999 Assessment Summary, although dictated, was not officially completed until January 4, 2000, when his supervisor approved it.

Illg said he contacted Watkins on three separate occasions, asking her to take Shelby to the doctor to be examined. In his February 4, 2000 Assessment Summary⁵⁶ concerning Shelby's death, Illg noted he spoke with Watkins "on or about 12-17-99, and urged her to have Shelby seen by a physician."

I explained to Heidi that our office continued to receive calls about the injury to Shelby's forehead and that there was a concern that Shelby had a rash on her vaginal area. Heidi stated that she would take Shelby to the doctor.

The Ombudsman asked Illg why he requested Watkins take Shelby to the Dr. Illg indicated it was primarily, at least initially, for Watkins' protection:

[W]hen I spoke with Heidi I told Heidi it was for her own protection to have the child seen by the doctor. And then if the doctor said there is no problem here, you know, then when I got these calls, I ... would know how to handle them....

I don't want to see somebody repeatedly turned in for doing something they didn't do. And if Heidi takes the child to the doctor and the doctor says absolutely that could happen, I'm very comfortable with that explanation, then that's for her protection....

If Heidi wasn't doing anything to hurt Shelby, then I want a doctor to say "You are not doing that" so that if anyone harasses her she can say, "I took her to the doctor, go ahead and talk to the doctor."

Clay County DHS Office telephone records show Illg tried to reach Watkins at her home on four occasions. However, it is not known if he spoke with Watkins on each occasion.

Date	Time	Minutes	From	To
12-13-99	4:21 p.m.	2	Clay County DHS	Watkins
12-15-99	2:33 p.m.	1	Clay County DHS	Watkins
12-16-99	1:14 p.m.	2	Clay County DHS	Watkins
12-17-99	11:47 a.m.	1	Clay County DHS	Watkins

⁵⁶ See Appendix J, *Child Protective Assessment Summary Part A; Child Protective Assessment Summary – Part B*. This is the version prepared by DHS for public release, with redactions of information that DHS believed to be confidential by law.

In response to the Ombudsman's question when and how he learned of Watkins' home telephone number, Illg said he did not remember, but he did not think he got it from Dawson.

The Ombudsman finds that, on December 13 and 15, 1999, Illg tried to reach Watkins by telephone right after speaking with Dawson. Illg also tried to reach her on December 16 and 17, 1999. Illg either spoke with Watkins or left a message. At least on one call, Illg talked with Watkins or left a message regarding concerns he had received about Shelby, and asking Watkins to take Shelby to the doctor. These calls from Illg were all made to Watkins' home telephone number.

The Ombudsman also finds that Illg first learned of Watkins' home telephone number from Dawson on December 13, 1999, just as Dawson testified. There is no evidence that Illg ever attempted to call or did call Watkins at her home prior to December 13, 1999. When he dictated his Assessment Summary early that morning, he left her number blank. Later in the day, after talking with Dawson, he called Watkins at her home. All subsequent calls from him to Watkins were made to her home.



December 21, 1999

According to Lakes Family Practice medical records, Watkins missed a scheduled doctor's appointment for Shelby on December 21, 1999.

December 21 – 22, 1999

Report from Karen Roseberry

Karen Roseberry told the Ombudsman that she called Illg around December 21, 1999 in response to calls she had received from Reverend Don Dressel and Kristy Linn.

And I got a telephone call from . . . Don Dressel, who is the minister of the of the Family Christian Center. And Kristy Linn, who had been getting telephone calls from this Sherry Dawson – Sherry Dawson had seen Shelby and had – was terribly concerned for her life, that she was being beaten brutally and abused brutally, and was not getting any satisfaction with any phone calls and wanted to know if there was anything I could do to help. And I said, 'I know Chuck. I'll call him. I'm not in the daycare anymore. I don't know if it will do any good or not.'

Roseberry said the following exchange occurred when Illg returned her call.

And he said, ‘Karen, I have been screamed at, yelled at, called every ungodly name.’ And I said, ‘Well, my God, Chuck, listen to these people. Get Shelby out of that house. Get her out of there.’ And he said, ‘Karen, I’ve been doing my job for 17’ – or some umpteen years – and he said, ‘I really think I know my job just a little bit better than you.’ I said, ‘All right.’

Illg told the Ombudsman he remembered Roseberry talking about a call she had received from a nurse or nurse’s assistant. Illg said he surmised the person who called Roseberry was Dawson because Dawson had earlier told him she was a certified nurse’s aide. He said he did not recall Roseberry mentioning Dressel or Linn during that call.

Clay County DHS Office telephone records show one call to Roseberry’s home on December 22, 1999 at 3:09 p.m., lasting 12 minutes. Illg said that call was probably his return call to Roseberry.

Date	Time	Minutes	From	To
12-22-99	3:09 p.m.	12	Clay County DHS	Roseberry

DHS has no other documentation of Illg’s call to Roseberry. Illg did not complete an Intake form. He said he did not believe Roseberry had any new or firsthand information; he believed she was describing injuries he had seen on Shelby on December 3, 1999.

The Ombudsman finds that Roseberry called Illg on December 21, 1999 and heard back from him on December 22, 1999. Roseberry told Illg she had heard an allegation of abuse concerning Shelby. Illg believed the source for Roseberry’s information was Dawson. Illg did not document Roseberry’s call as an intake. It is not known what he told Roseberry regarding any decision or what he was doing with her call.

December 21 – 22, 1999

Kristy Linn’s Call to DHS

Kristy Linn told the Ombudsman that Dawson called her sometime in December and told her about “various bruises that Shelby had on her body” and that Dawson was not happy with Illg. Linn said she called not only Roseberry, but also Illg and his supervisor, in response to Dawson’s call.

Linn testified she called Illg in mid-December 1999; however Illg didn’t return her call, so she called again, this time she asked to speak to his superior. She said the receptionist told her Illg’s supervisor was on vacation, so she left a message, asking for a return call. In her message, she stated she was calling about an “abused child,” but did not mention Shelby by name. She said nobody called her back.

Illg testified he did not recall getting a call from Linn in December 1999.

Paula Heckenlively, the Human Services Area Administrator (HSAA) for the Spencer Cluster, remembered a call from Linn. Heckenlively said she took a message on her voice mail from

Linn and wrote down Linn's name and number on a piece of paper. She said Linn did not indicate in her message that she was calling about child abuse.

Heckenlively said she called Linn at least three times but did not reach her.

[T]he first call I know was, I was like in a two-hour meeting ... like 9 to 11. I got out, had the message, tried to call, I didn't get an answer. There wasn't any answering machine.... [I] believe I tried to call again that day and I know I tried to call the next day at least once. So it's either two times the first day and one the following day.... My practice is to attempt three times.... [I]f she would have said it was child abuse, it would have been a different effort made.... [I] would have been much more insistent in calling her back.

The Ombudsman finds that Linn tried to call Heckenlively on December 21, 1999 regarding what she had heard from Dawson concerning Shelby. However, given the conflicting testimony, the Ombudsman is unable to determine that Linn specifically mentioned child abuse in her message to Heckenlively and that Heckenlively consequently knew if Linn was calling to make a report of child abuse. Since there is no evidence to the contrary, the Ombudsman believes that Heckenlively did try to call Linn back three times, but was unsuccessful in reaching her.

In addition, given only conflicting testimony regarding Linn's alleged call to Illg, the Ombudsman is unable to find that Linn called Illg and left a message for him.

December 22 – 27, 1999

Contacts from Rev. Donald Dressel

Rev. Donald Dressel told the Ombudsman he learned about Shelby when he read his wife Gwen's college class report about her 2-day observation at Small World Day Care. He said the report "alarmed" him, so he talked with Roseberry to get more information about the family. Afterwards, he called the Hotline to get the telephone number for the Clay County DHS Office. He called the Office and left a message for a child abuse investigator to call him.

- **Contact to Clay County DHS Office**

Rev. Dressel testified he spoke with a secretary at the Clay County Office and left a message asking a child abuse investigator to call him. He said he gave the female he spoke with the names of the people he was calling about.

Diane Clasing, a secretary/receptionist in the Office, took Rev. Dressel's call. She said Rev. Dressel had concerns about a child in Spirit Lake, but did not identify the child. She talked with both Illg and Morey about it, and remembered Illg saying something like, "Give me the message because I have an idea I know who it's about."

Rev. Dressel said Illg returned his call and left a message on his answering machine. He called Illg back, left another message, but Illg never called him again

Illg confirmed Clasing gave him the message from Rev. Dressel, indicating he had concerns about a child in Spirit Lake. He did not believe Rev. Dressel identified the child, and he did not know if he connected Rev. Dressel's message to Shelby at the time. He returned Rev. Dressel's call, got his answering machine, and left a message.

Illg told the Ombudsman he returned Rev. Dressel's call the same day or the next day, got his answering machine, and left a message. He said he tried calling Rev. Dressel back a second time, got his answering machine again, but this time he did not leave a message.

Telephone records from Rev. Dressel and Illg's Office showed the following calls:

Date	Time	Minutes	From	To
12-22-99	12:38 p.m.	3	Dressel	Clay County DHS
12-23-99	11:18 a.m.	1	Clay County DHS	Dressel
12-27-99	10:54 a.m.	3	Dressel	Clay County DHS

The telephone records only show one return call - - on December 23, 1999 - - to Rev. Dressel. There is no other documentation that would confirm that Illg called him back a second time.

In response to the Ombudsman's question why he waited almost a day to return Rev. Dressel's first call, Illg said he assumed clerical staff had screened the call and it was not a "child abuse report in the making sitting on my desk."

- Contact to Dickinson County DHS Office

Around this time period, Rev. Dressel also called the Dickinson County DHS Office concerning Shelby, and after that call, he also contacted the General Relief Office.

[I] proceeded to call the Spirit Lake Human Service Office, and they said, 'This is none of your business, keep your nose out of it.' That upset me, but I don't give up too quickly, so I called the Dickinson County General Relief Office – Beth [Will] is a good friend of mine – and gave her all the information, and she says, 'Don, I will turn this information over to the proper authorities,' and I didn't hear any more until January 4th... I assumed that people were doing their jobs.

Beverly Beer, a typist/receptionist in the Dickinson County DHS Office, took Rev. Dressel's call, made a note of the call and gave it to Case Manager Deb Nelson.

Beer testified Rev. Dressel wanted to know what DHS was doing on Shelby's case and she told him that "it was confidential information." Beer said in her note to Nelson, she wrote something like, "Mr. Dressel had called and was wanting information on the Duis case." Beer thought Nelson indicated that "he had called Chuck [Illg]."

Rev. Dressel did not receive any contact from Nelson or Illg about this call.

Contact from Beth Will

Beth Will, Coordinator, Dickinson County General Assistance, recalled Rev. Dressel's call to her.

[H]e said something needs to be done ... and so I said ... I can call the local office and, you know, ... follow through to make sure that the case is being followed. At that time he did give me the mother's name of Heidi Watkins. And also the concern of her daughter.... [H]e just gave me the first name of Shelby.

Will testified she immediately called the Dickinson County DHS Office and was referred to Deb Nelson. Will said she told Nelson she had received a call concerning Watkins and her child and from Rev. Dressel, and that "he was concerned about some neglect and some possible abuse...some bruising."

Will said Nelson responded by saying "she was aware and ... it was a case of hers, and that she had been working on it ... that she would take that information and work with it."

In an e-mail to Heckenlively dated February 8, 2000, Nelson acknowledged she had received the call from Will. She said she did not think Will was reporting abuse, "but rather expressing concern."

Will said she expected Nelson or a child abuse investigator to follow-up.

I would [expect] some kind of follow-up, or call back, or a question, or, I guess I wasn't sure whether it would ... she would refer that to Chuck Illg or ... what's the other gal's name who does some investigating or call Mr. Dressel.

Neither Will nor Rev. Dressel received any follow-up contact from Nelson or Illg.

The Ombudsman finds the Clay County DHS Office took a message on December 22, 1999 from Rev. Dressel indicating he had "concerns about a child." Given conflicting testimony, the Ombudsman is unable to determine if Illg knew the call was concerning Shelby. Illg did not consider the call a report of child abuse. Illg called Rev. Dressel back a day later and left a message. However, after Rev. Dressel called a second time on December 27, 1999, Illg made no subsequent efforts to call him back.

The Ombudsman finds that Rev. Dressel also contacted the Dickinson County DHS Office sometime in middle to late December, inquiring into DHS's involvement with Shelby. The Ombudsman is unable to determine if he sufficiently conveyed to Beverly Beer, the receptionist, that he wanted to provide or report information about Shelby.

The Ombudsman is unable to determine from the testimony exactly what information Deb Nelson received from Beth Will. Although Will said she mentioned possible abuse and some bruising, Nelson said she was only "expressing concern."

The Ombudsman finds that Nelson did not consider Will's call to be a report of child abuse and therefore did not relay it to an intake worker.

December 23, 1999

According to his February 4, 2000 Assessment, Illg telephoned Nelson on December 23, 1999 "to ask her if she could follow up on whether or not Heide followed through with having Shelby seen at the doctors office."

Illg explained to the Ombudsman that he asked Nelson to follow-up because she was the ongoing social worker and "it was time for the case to be handed off."

There were in-home services in the home. They were up there in Spirit Lake. And even though technically my investigation was open, I just - I thought it was time for the case to be handed off... [O]nce a social worker is assigned and in-home services are in the home, we usually drift out of their cases.

Illg said, "[I]t was [Nelson's] role and the in-home worker's role to facilitate the doctor's appointment, to help line it up, to help provide transportation, whatever else was needed."

[REDACTED]

Nelson testified she immediately informed Illg of Watkins' plan via e-mail, at 1:30 p.m. She said she told Illg that [REDACTED], the in-home service provider, was meeting with Watkins at 3 p.m. that day and that Watkins would show Shelby's injuries to [REDACTED].

Illg's February 4, 2000 Assessment Summary indicated he called the doctor's office on December 23, 1999 and was told that they could not confirm if Watkins had called for an appointment, but they did state the doctors in the office were "booked on that date." Clay County DHS Office telephone records show a call to Lakes Family Practice at 2:28 p.m.

Date	Time	Minutes	From	To
12-23-99	2:28 p.m.	3.0	Clay County DHS	Lakes Family Practice

Nelson said she did not try to contact [REDACTED] because she "trusted" Watkins to show Shelby's injuries to [REDACTED]. She also assumed [REDACTED] had already left her office to go to Watkins' home, and she did not have [REDACTED] cell phone number.

[REDACTED]

[REDACTED]

Nelson said she did not “touch base” with [REDACTED] about her December 23, 1999 visit with Watkins because she counted on [REDACTED] to call her if she had concerns.

I guess I just assumed that if [REDACTED] would have had any concerns, she would have called, and she didn’t call.

Illg said he did not believe he was obligated to call [REDACTED] either.

[REDACTED] is a mandatory reporter.... I mean, it’s her job as an in-home provider to if there are concerns ... report them to Deb, who will report them to me. I don’t want to sound flippant, but every case we have where there is an in-home worker, it’s not our responsibility to call after every home meeting to say ... how did that go....

[REDACTED] told the Ombudsman that, based on what she knew and observed on December 23, 1999, she did not believe she had an obligation to make a report to DHS as a mandatory reporter. She said that she called Nelson on December 29, 1999 “to update her.”

Nelson testified she had no further contact with [REDACTED] until December 29, 1999. Illg testified that he did not find what occurred on [REDACTED] visit until Nelson told him on December 29, 1999.

The Ombudsman finds that Illg called Nelson on December 23, 1999 and asked her to follow up with Watkins to find out if Shelby had been seen by a doctor. Nelson then called Watkins, and Watkins told Nelson she could not get a doctor’s appointment because she did not have the money and the doctor was too busy. Watkins also told Nelson she planned to show Shelby’s facial and vaginal area injuries to [REDACTED], the in-home service provider, later that day. Nelson reported Watkins’ plan to Illg, but did not notify [REDACTED] about it.

The Ombudsman further finds that Nelson and Illg relied on Watkins to show [REDACTED] the injuries to Shelby’s facial and vaginal area, and expected [REDACTED] to report any concerns she might have about the injuries.

[REDACTED]



December 29, 1999

Nelson testified that [redacted], the in-home service provider, telephoned her on December 29, 1999 and said that “Shelby’s eyes looked really bad.” When she questioned Watkins about them, Watkins stated, “Yes, they do look bad. Chuck and Deb have already seen them.”

Nelson said she asked [redacted] if she had checked Shelby’s vaginal area and [redacted] replied, “Heidi didn’t mention that she was supposed to look at it.”

Nelson then e-mailed Illg about what [redacted] told her. She also indicated that she was “really wondering” if what [redacted] observed was the same injury they had seen on December 3, 1999.

[redacted] went to Heide McKnight’s home last week. Heide did meet with her, but did not show [redacted] the sore vaginal area in question. [redacted] stated that Heide never mentioned it. [redacted] stated that Shelby’s eyes looked awful. Now, I am really wondering if the black eyes were from the same injury that you and I witnessed that day at [redacted] home. I didn’t think her eyes looked that bad.

Illg sent the following e-mail reply to Nelson the same day:

Why did [redacted] not ask to look? Maybe she did not know our concerns when she went out? Did Heide give any explanation as to why the eyes looked so bad other than from the black eye on 12-3-99[?] When is she going to meet again? I have about lost all patients [sic] with this lady!!!!!!! I am going to write a letter to the county attorney and send it to Heide and tell her that it will be sent if Shelby is not seen by a doctor this week or if she misses one more appointment. I am done with her.

Nelson e-mailed Illg again in reply, explaining why she did not contact [redacted] beforehand. She also told Illg she and [redacted] had doubts about Watkins’ explanation for the soreness and redness in Shelby’s “diaper area.”

It was too late in the day for me to catch [redacted] in Sioux City so she was unaware of our concerns. [redacted] has four cases for me so was already on her way here or here by noon on Thursday [12-23]. I trusted Heide when she said she would show [redacted]. [redacted] and I talked about the reason that Heide had given for the soreness and redness in the diaper area. We have come to the conclusion that her reason is a bunch of crap. Rarely do one’s hands actually touch the skin when changing a diaper. Usually, wiping is done with a diaper wipe or a cloth. If the child is just wet, often times the skin is not touched with anything, but the diaper just changed. Unless, she is powdering her everytime and rubbing that in with her

hands, I doubt she touches her. Anyway, I am very suspicious since Heide promised me that she would follow through with [] and then she didn't.

Illg's February 4, 2000 Assessment Summary stated only the following about his communication with Nelson: "On 12-29-99, this worker learned from Deb Nelson that Shelby still had not been seen by a doctor."

The Ombudsman finds that Nelson told Illg on December 29, 1999 that [], the in-home service provider, thought Shelby's eyes "looked awful" on December 23, 1999. Nelson also indicated to Illg she was "wondering" whether what [] saw was from the same injury they had seen on December 3, 1999. Nelson also told Illg that she had doubts about Watkins' explanation for the reported vaginal area injuries.

December 30, 1999

Illg sent a letter to Watkins on December 30, 1999, telling her to take Shelby to the doctor and not miss another in-home services meeting. In the letter, Illg said if she missed another meeting or if he did not hear from Watkins by 4:30 p.m. on January 3, 2000, he would send a letter to Jack Bjornstad, an Assistant Dickinson County Attorney.

Illg also told Watkins, in that letter, what to tell the doctor.

Tell him or her that the injury to the face is from a fall prior to 12-2-99. Tell him or her that Shelby's vaginal area was looked at three months ago. Explain what you have doing to treat it. Explain who the doctor was who saw Shelby on that date and what he said.

Along with that letter, Illg enclosed a copy of the letter he would send to the county attorney if Watkins did not comply with his demands. In that letter to the county attorney, Illg discussed his reasons for requesting a "Child In Need of Assistance" petition. He stated he had received "several concerns that Shelby's eyes and face were swollen" and "that Shelby had sores and discoloration on her vaginal area." He stated he had told Watkins several times to take Shelby to the doctor, but "it has still not been done." He stated he has "alarming" pictures of Shelby that can be used in court. He also stated Watkins has missed appointments and is refusing to meet with the services provider.

Illg told the Ombudsman, "[I]n layman's terms, I piled it on heavy and I piled it on high." He said he "would never send a letter like that to Jack [Bjornstad] because I can't support what was in there." He said, "That letter was for effect. . . . I wanted that child seen, and I wanted to send that to Heidi. Had Heidi not taken the child to the doctor on the 3rd I would have requested – that an adjudication be scheduled for CINA."

Illg also told the Ombudsman even though he did not believe he had sufficient grounds for an adjudication on the petition, he still would have asked to file it.

I really do think it would have been iffy, because we do have unconfirmed reports. I could have showed him these photographs [taken 2-22 and 10-21-99], but then he

already has the report that the doctor said no, these explanations match. What may have gotten Shelby adjudicated is Heidi agreed to services and she wasn't meeting with the in-home provider. That may have been enough for this judge. But I don't know, again, who you are going to talk about with this judge ... I'm not saying this is right, but when you work with a judge sometimes this does become a part of your decision making. Okay. We're not going to get an adjudication on this so let's do the in-home thing.

The Ombudsman finds that Illg responded to [redacted] and Nelson's concerns regarding Shelby's injuries by writing a letter to Watkins, demanding a doctor's visit and no more missed service appointments, and threatening to request the filing of a "Child in Need of Assistance" action if she did not comply.

January 3, 2000

Illg testified that Watkins called him on January 3, 2000 in response to his letter and said she had a doctor's appointment scheduled for Shelby that day at 5:00 p.m.

[redacted]

According to Lakes Family Practice medical records, Dr. Kalkhoff saw Shelby on January 3, 2000. Dr. Kalkhoff's progress notes indicated he saw a child with "sores on her bottom" and "bruising about her eyes and on her forehead."

Regarding the bruising, he noted, "Mom states that she fell about 1 [month] ago at home and that she bruises quite easily." He also noted the following: "Bruising, difficult to tell the etiology of this. Abuse has been questioned in the past and was just worked up in October and November of 1999."

Dr. Kalkhoff's progress notes also mentioned "a lesion in her [right] labia consistent with a yeast vs an infection lesion" and "a lesion under the chin that she states was aggravated by the cast that she had on."

In a January 5, 2000 addendum to his progress notes regarding Shelby's January 3 visit, Dr. Kalkhoff writes the child had "a bruise on her forehead that was darkening and becoming yellowish which is consistent with an old bruise and consistent with the time frame for 3-4 weeks that Mom described. The bruise was also becoming more dependent about her eyes; both eyes were bruised and darkened."

Regarding the bruise, Dr. Kalkhoff told the Ombudsman:

It was looking yellow and discolored, consistent with an old bruise. It was becoming dependent about her orbits.... I would say it was several weeks old or a good couple weeks old at least.... [T]he swelling part of the bruise was between her eyebrows. There wasn't swelling around her eyes but discoloration.... A yellowish, light blue.

Illg did not contact the doctor before the examination to inform him of the reason for Shelby's visit. When asked if his examinations generally would be different if he knew DHS were involved, Dr. Kalkhoff said, "I think the whole physician-patient visit changes with the reason for coming to see you." He said the examination, as well as the "history," would be different.

If I thought there was a suspicion of abuse or neglect ... my exam would be more involved.

[Y]our whole outlook on the visit changes from a mom here or dad here bringing in their child and concerned about what's wrong versus I'm forced to be here. I mean, your history about what happened, well he fell and bumped his head. Well we hear that everyday. Now if there's suspicion, you'd follow that up a whole lot more. Does this make sense? Are they covering their tracks? Did they seek medical attention?

Is the explanation consistent? Does anybody else know about this? Is the person credible? You know, all the way back to . . . who else is in the home? Where else does this child go?

When asked if his January 3, 2000 examination of Shelby would have been different had he had been contacted by DHS in advance, Dr. Kalkhoff said, "I think it would depend on ... what DHS told me."

I mean, no if they said we were there and we noticed this bruise and it's been there for three weeks and we think she's fine or I don't know what it would have changed. If . . . the report is that this bruise is getting bigger and we have a dozen reports and check her out more, I mean would I have done something different or x-rayed or something to tip that, I guess we don't know. But I think it would have been good to know those things.

If I know that this visit is a forced visit by DHS, I think that changes the scope of things and ... certainly in hindsight, what would I have done different? I don't know. I think it probably depends on ... what my information was at the time but I do think it changes the presentation of a visit a lot and I don't know if that's in confidentiality laws that they can't call us and tell us that these things are happening or what.

Dr. Kalkhoff told the Ombudsman that if he had known the earlier appointments missed by Watkins were “pressured” by DHS, he would have called DHS and reported them.

These missed visits [on 12-16, 12-21, and 12-22-99], if we know that these are pressured by DHS ... we would follow up and at least call them, well, they didn't come, what was the reason for their visit?

January 4, 2000

Watkins found Shelby's lifeless body in her bed, and called 911. Dr. Brett Olson, Dickinson County Coroner, came to Watkins' home and declared Shelby was dead. On the “Certificate of Death” that he completed, Dr. Olson noted the manner of death as “homicide” and the immediate cause as “multiple blunt traumatic force injuries.”

Post-mortem Examinations

Dr. Brad Randall, Forensic Pathologist, conducted the autopsy of Shelby's body on January 5, 2000. Dr. Susan Duffek, Pediatric Radiologist, reviewed the post-mortem x-rays taken of Shelby's body, as well as the x-rays taken at the Lakes Family Practice on October 21, 1999.

Drs. Randall and Duffek testified at Wendelsdorf's and Watkins' criminal trials regarding injuries to Shelby's head, chest, abdomen, hands, and genital area that ranged in age from several days to several months.

Head

At Wendelsdorf's trial, Dr. Randall testified he saw evidence of old bruising on Shelby's head.

There was evidence of bruising that appeared to be at least of a week or two or perhaps older age and then the possibly some bruising in between, of several days age.

Chest

Dr. Randall testified he found “old fractures of the ribs on the left side, ribs 4 through 9” that “appeared to be at least one to two weeks of age, probably a little older than that.”

What was found on the internal examination of the chest was evidence of old fractures of the ribs on the left side, ribs 4 through 9, kind of halfway between the outside of the chest and the middle of the chest and what we would refer to as basically the nipple line. The fractures were older. They appeared to be at least one to two weeks of age, probably a little older than that.

At Watkins' trial, Dr. Duffek testified she saw “multilateral fractures of the ribs,” 5 through 9. She testified she believed the rib fractures occurred “two to six weeks” before death.

The rib fractures also were in a state of healing. There was quite a bit of periosteal new bone surrounding the rib fractures. They were similar in appearance, and I felt they were between two to six weeks in age.

Dr. Duffek also testified she believed the “rib fractures would be painful for several weeks.”

Abdomen

Dr. Randall testified Shelby suffered a significant “blow or blows to the abdomen,” a week or two before her death.

[A]t some point in the past and again at least one to two weeks in the past, there had been a blow or blows to the abdomen that had scarred the mesentery. When someone receives a blow to the abdomen, the intestines usually get out of the way. They’re just floating in your abdomen. So they can get out of the way of a blow but the mesentery is tethered there. It’s fixed to the backbone. It doesn’t have anywhere to go. And so when there is a blow to the abdomen, the mesentery gets crushed between the blow and the backbone, and it gets scarred. And that’s what happened in Shelby’s case. This mesentery, which is really supposed to be more fat than scar, than fibrous tissue, in this case was more fibrous tissue than fat. And it had blocked – the scarring had blocked and plugged up all of these lymphatic channels so they had expanded and ruptured and the – this bile material, that’s supposed to be going from the intestine back to the blood supply, was being plugged up and was then leaking into the abdomen. And it is just a marker of significant abdominal trauma happening sometime in the past.

Under cross-examination, Dr. Randall testified the mesenteric scarring could have occurred anywhere from two to three weeks or six to eight months before death.

Hands

Dr. Randall testified he found fractured metacarpals in both hands, ranging in age from two or three weeks to three or four months.

Dr. Duffek testified she reviewed the hand x-rays taken by Lakes Family Practice on October 22, 1999 and found the following:

On the right second metacarpal, I felt there was some periosteal starting to lay down on the fracture. It was a small amount. When you see that, the fracture is at least 10 days old, and I estimated since there was a small amount, it would be 10 to 20 days of age.

Dr. Duffek testified she reviewed the post-death x-rays and found more recent fractured metacarpals, in both hands. She testified she found five fractured metacarpals in all, occurring as a result of three separate injuries.

The x-ray of the right hand again showed the right second metacarpal fracture which was at this point well-healed. There was also a fracture of the right third metacarpal and right fourth metacarpal....

The third metacarpal fracture had periosteal new bone formation more than the fracture that I will talk about briefly in the left hand, and the amount of periosteal formation on the third metacarpal showed this was approximately three to four weeks of age....

The injury to the fourth metacarpal was more subtle. There was a small amount of sclerosis or whitening to the bone, and there was no periosteal formation, and without that I didn't feel I could date the fracture....

On the view of the left hand, there were fractures of the left second and third metacarpals....

These two fractures had a thin line of periosteal new bone formation, not as much as the third right metacarpal, and with a thin line, I felt they were within the two-to-three-week range.

To summarize, we have five metacarpals, and three of these were different ages. So there were three separate injuries to the hands with the second metacarpal fracture the oldest, the right third metacarpal fracture would be in between and then the most recent fractures being the second and third metacarpals fractures of the left hand.

Dr. Duffek testified the fractures would be painful and would probably exhibit swelling and bruising.

Most of the time you will get swelling you can detect, but sometimes children have very chubby hands, and you may not be able to detect it.... [U]sually you would have bruising associated with it, discoloration of the skin.

Genital and Rectal Area

Dr. Randall testified he saw "extremely bad diaper rash."

...bad to the point that the surface of the skin had become ulcerated or rubbed away, and that there was then ulcerations or loss of the surface of the skin over the labia around the entrance to the vagina, and in little – in discreet areas surrounding the anus or opening of the rectum.

Medical and Child Abuse Consultant

Dr. Rizwan Shah served as a paid medical and child abuse consultant to the Ombudsman. Dr. Shah has been licensed to practice medicine in Iowa since 1974, and has been a board-certified pediatrician and a fellow of the American Academy of Pediatricians since 1979.

Since 1989, Dr. Shah has been the Medical Director of the Child Abuse Program at Blank Children's Hospital in Des Moines, Iowa. Her duties include providing medical evaluation and diagnostic services for children who may be victims of child abuse; providing child abuse consultation services to physicians, legal professionals, and human services officials; training medical professionals to evaluate and diagnose child abuse; and providing mandatory reporter training for primary care physicians in the Iowa Health System.

Dr. Shah estimates in her 19-year practice involving child abuse, she has seen on average 400 to 600 children every year for alleged sexual abuse, and has served as a consultant in 50 to 100 other cases each year involving child abuse or neglect.

Besides providing general information about bruising, hand fractures, diaper rashes, and sexually transmitted diseases, Dr. Shah also examined photographs taken of Shelby before and after death and offered her opinions as to the nature and causes of the photographed injuries.

This section presents and summarizes Dr. Shah's expert observations, opinions and information regarding Shelby's injuries as seen on the photographs taken by Illg on February 22 and October 21, 1999. It also presents and summarizes her observations, opinions and information regarding alleged new bruising in December 1999, as well as recurring diaper rash, and the visible differences between diaper rash and sexual abuse.

Injuries Photographed on February 22, 1999

After examining photographs of Shelby's face taken by Illg on February 22, 1999, Dr. Shah told the Ombudsman she saw linear bruises and said, "I would give it a 90 percent possibility that it is a handprint...." She further opined it would have a much lower possibility (10 percent) of being caused by contact with a doorframe.

According to Dr. Shah, the bruising under the eye does not match the offered explanation. She characterized the location and shape of the bruise as suggesting a hand striking the face, not contact with a doorframe.

In reaching her opinion, Dr. Shah made the following observations:

- "Well, the first thing that I notice which is consistent in all of the photographs – the five photographs that you've given me – is that these are one-sided injuries, one-sided bruises."

- “The location is on the cheek and underneath the eye. None of these areas are typically the first areas that come in contact with the outside surfaces in typical accidental injuries.”
- “The bruise under the eye, even though it may be designated as a black eye, actually is a little bit different in that it just surrounds only the lower part and does not surround or circle around the eye like we see typically in blood coming from a broken vein on the nose....”
- “ This is an area that is more protected. I can see it on the cheekbone. The side bruise on the cheek on the two sides, even though there are two lines there with a clearing in between, I would – if I was looking at those photographs as a consultation, I would advise people to go and measure the breadth of the door frame where this child had come in contact with and compare it with these linear bruises and see if they match.”
- “[A]nd in the back of my mind would be that these areas of the bruise could may well have been an impact with a hand that popped the blood vessel underneath the eye also with an impact.”
- In response to the Ombudsman’s question if the shape of the bruise in any way suggests that it could have been caused by a hand striking the side of her face, Dr. Shah responded, “Yeah, the two lines.... [T]he location and shape of the bruise on those two lines separated by a clear area in the middle suggest a hand striking the face.”
- “[A]gain, the location is very important, not only the shape, because it would be more vertical because you will come on the side, like that. The door is standing vertically and the child comes in contact in a vertical running position. The child does not run at an angle. This bruise is at an angle.”

Dr. Shah answered in the affirmative to the Ombudsman’s question whether she would expect an experienced CPW to find the linear bruises suspicious.

Dr. Shah said the bruises on the forehead, because of their location, “can be consistent with accidental injuries.” She said the forehead bruises did not occur at the same time as the linear bruises on the cheek.

Injuries Photographed on October 21, 1999

After examining the photographs of Shelby’s face, hand, and back, taken by Illg on October 21, 1999, Dr. Shah told the Ombudsman she believes the hand fracture and the back bruises are intentional, abusive injuries.

Dr. Shah opined falling from the crib or catching the hand in the crib is not an explanation that matches an isolated, fractured metacarpal. Dr. Shah reached her opinion after making

observations and told the Ombudsman:

- “First, there is not that much -- there is no swelling of the wrist involved. Most of the swelling involves almost three-fourths of the hand up to the first knuckles of the first two fingers and thumb. The other significant thing in that is that except for the area of a localized dark bruising at the base of the index finger, second metacarpal, there is not external injury. No break in the skin. There is a lot of discoloration, which indicates that there is a significant amount of blood that has leaked....”
- “Also, the location of the biggest impact is on the base of the first finger and very isolated, and I said that the child’s hand is too small to get caught in that – that location.”
- “...the kind of location of the swelling is not consistent with the hand being caught in the crib....”
- “The child’s area of the swelling is pretty close to the grip where the child holds something if they are trying to fall to grab, and this will not likely get tangled into the grip of the crib bars that they are talking about.”
- “There is no extensive involvement of the – the wrist, which is the most [common] area where things can get caught because of the child slipping and not being able to pull the whole hand out.”
- [Falling out of a crib] “(w)ould not match with an isolated metacarpal injury, no, because, in that, typically the position of the hand is such that more force is borne by the wrist, and if anything will break in a fall, it will be the wrist bone rather than a metacarpal.”
- “If the hand got caught in the crib during the fall, then it will be more than one bone that should be affected, not just an isolated bone, because a child’s hand is too small to get caught in the cribs. A grown-up’s hand is too small to get caught in a crib.”

Dr. Shah told the Ombudsman none of the bruises on the back are consistent with “everyday bump bruises” or with other children picking up Shelby. Dr. Shah explained:

- “I see multiple areas ... six-plus areas of bruises yellowish brown. Some have a little more darker tint than others in some pictures, and they are scattered on the area of the flank on either side of the spine except for one, but none of them is on the bony area of the spine.”
- “They are all roughly circular, and in picture number two, just above where she has the line of the diaper, there are three bruises that are close together.”
- “Neither the location nor the shape of the bruises is consistent with somebody picking up, and the younger children do not have a sustained pressure to break the blood vessels to cause blood collection under the skin that causes a bruise.”

Dr. Shah answered in the affirmative to the Ombudsman’s question whether she would expect an experienced child protective worker to find the hand and back injuries suspicious. The Ombudsman summarizes or quotes her reasoning as follows:

- The child shows a pattern of injuries that varies in the time frame. Some of them are very recent, some of them are of the recent past, some of them are significantly in the background, and there is a pattern.
- “If I put all of them together, I would say that from a blunt area on the abdomen going to a bruise on the face that looks in the recent past to a very acute injury to another fairly acute

accidental injury [the toe], this child, in my mind, is not a protected child, and the child needs to be in a safe environment outside of this home where the child is faced with intentional injury over a period of time.”

- “This would tell me that this is now a fracture of the bone, and we have gone from the bruising on the flanks to fracture of the bone; that [hand] injury is serious, and that is a threat to the child’s life.”
- “I would expect the Department of Human Services assessment worker to have a suspicion that location and the number of bruises is too many for my comfort level....”

Dr. Shah said, “Some workers could have bought into the story of [how] this happened, being caught in the crib. It will require some knowledge and experience of thinking of what are the circumstances, and there the worker would need a medical professional to tell what causes that kind of an injury.” She also said, “A worker may not have recognized what is the mechanism involved in that... An experienced worker would have done that [gone out and examined the crib]. I wouldn’t say that all of them would. An experienced worker would have done that and then asked, ‘Gee, I think that could happen. Maybe I should ask somebody who knows.’”

Dr. Shah also said the child needed to be seen by a doctor as soon as possible. She made the following observations:

- “The pain will be a dull pain. It will not be excruciating because of the pressure that is built up from the collection of so much blood and the swelling. It will be like a pressure of a sprain, but every time she moves her hand, then that will be much more severe pain. That will be a sharp pain of the broken bone, but she will have pain -- dull pain all around....”
- “[A]n attempt needs to be made to have the child examined as soon as possible after somebody has noticed that injury, because the quicker you can -- if there is a fracture underneath it, the chances are if there were more than one break, you could have pieces shift from their position and it becomes sometimes hard to align them, and so as soon as possible the child needs to be evaluated for that. Medically it is necessary.”

Dr. Shah said the amount of swelling and discoloration, as shown in the photographs, suggest a recent injury. She told the Ombudsman if the fracture did occur 10 to 20 days previous (as Dr. Susan Duffek testified at the criminal trial of Heidi Watkins), then she believes the area of the fracture was re-injured. Dr. Shah told the Ombudsman:

- “[I]f a child suffered an injury that resulted in a broken bone, I would not expect the swelling to last 10 to 20 days . . . but it is entirely possible that either injury during day-to-day movement or compression, a new injury occurred and then that caused further damage to the soft cells, and then it caused the swelling on top of the broken area.”

Bruises

Dr. Shah told the Ombudsman, “Bruises are nothing but collection of blood from blood vessels that rupture under the skin, and that blood that is collected and is lying free under the skin has to be absorbed, and before it gets absorbed, the blood pigment has to be broken down.”

The Ombudsman summarizes or quotes her explanation of the resultant color changes as follows:

- The pigment that colors the blood red is the iron pigment in the protein called heme.
- In the chemical reaction involved in healing, that pigment is broken down.
- The subsequent by-products of that heme pigment are not red in color; they are of different colors.
- Depending on how the breakdown of that heme is occurring, a reflection of those pigments will be seen through the skin, which will give the color of the bruise.
- From a normal color of the blood that is bright red or rusty red, dark red, there are stages of reddish blue, bluish purple, purple-green, greenish yellow.
- When the red blood cells or heme pigment breaks down, it makes bile, the yellow-green color is of that, and then the iron in the blood gets oxidized with oxygen and becomes brown, the color of rust, and that’s the final stage.
- “A new bruise, a bruise that is pretty fairly new, less than like 24 hours old, will never show brown or yellow or green colors.”

Dr. Shah said, “And so even though there is a systematic way of breakdown of this pigment, a precise moment of hour cannot be assigned to them.” She further told the Ombudsman:

- “And therefore one has to be just sufficient in saying that if in a part of the body you are seeing a red mark, it is fairly a recent injury rather than saying it is thirty minutes old.”
- “Whereas, if you see a brown or a yellow spot where the bruise should be, then we can say that this is in a healing process, and we can safely say that this is not new but maybe a few days to a week plus old.”

Dr. Shah said most, but not all, bruises would be in the last fading stages in about three weeks.

- “Depending upon how much blood is collected and ... how the circulation is moving through, you can go through those changes in a short period of time, so instead of 21 days, you can clear it up in ten days.”

Bruising Observed on December 3, 1999

The bruising that Illg observed on Shelby’s face on December 3, 1999 allegedly resulted from Shelby falling and hitting her head against a box containing a toy on November 30, 1999. Dr. Shah’s opinion is that a bruise resulting from an injury on November 30, 1999 would not be visible over four weeks later, on January 3, 2000. She said if the doctor saw bruising, even in a

fading stage, on January 3, 2000, then he or she saw new bruising, resulting from an injury or injuries after November 30, 1999. She said, “We are dealing with an injury on top of an injury, yes.”

Recurring Diaper Rash Problem

After examining the January 5, 2000 autopsy pictures of Shelby’s diaper area, Dr. Shah opined, “She probably has had multiple diaper rashes that have never been taken care of on an ongoing basis.” She also said, “that degree of diaper rash should have raised a suspicion of child neglect....”

Visible Differences Between Diaper Rash and Sexual Abuse

Dr. Shah said location of injury is critical in distinguishing diaper rash from sexual abuse. She told the Ombudsman:

- “Diaper rashes usually occurs because the child’s body gets soaked in the urine and you get an ammonia irritation and the skin on the lips of labia Those discolorations on the lips of the labia, they all can be explained on the area because of the diaper rash. It’s because that’s the area that comes in contact with the urine-soaked diaper. The hymeneal area is protected because most of the--the lips of the labia partially cover the hymeneal, also a lot of infection cannot grow and multiply in the vaginal secretion of a young girl because of their chemical composition. So diaper rash really don’t extend in towards the hymen. And even the severe of the diaper rash just around the outside of the skin may be a little bit on the labia and clitoris, but don’t go inside the vagina.”
- “If the child has sexual transmitted diseases . . . like herpes and gonorrhea, you can have some of those infections that extend into the labia.”

Dr. Shah said when faced with allegations of sexual abuse based on redness and sores in the vaginal area, child protective workers should be especially concerned if the alleged injuries include blistering or blistery lesions and/or discharge. She told the Ombudsman:

- “Many times if there is concern enough that this is anything but an ordinary diaper rash when there is a blistering, when there is a discharge associated with the rash, that’s when the social workers should be concerned enough to have a second opinion.”
- “Because at this time you need to verify if this is really a diaper rash or this is really a sexual abuse from sexually transmitted diseases like herpes.”
- “[W]hen most of the time we get concerned about if they are blisters, whether or not it’s herpes. And herpes blisters occur in groups like a bunch of grapes. When there are skin infections like strep or staph, you will have isolated one blister here, one blister here, one blister here, like chicken pox. Also the skin reaction around the infection of the herpes is much more intense and discomfort is much more intense, sometimes the kids will hurt so bad they stop peeing. They have so many sores.”

Analysis and Conclusions

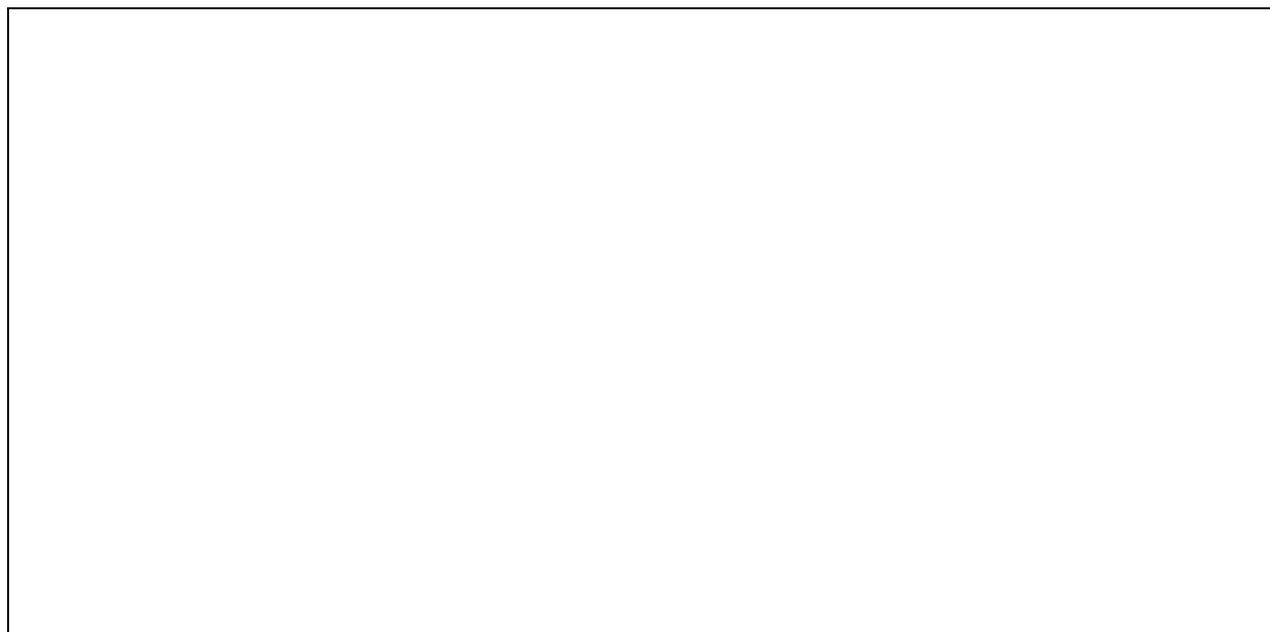
The Ombudsman has identified a number of policy and practice issues related to the reporting, intake, and investigation or assessment processes. This section of the report examines those issues and discusses the Ombudsman’s conclusions (in italics) relevant to those issues. The analysis and conclusions are based on the laws, policies, and procedures that were applicable at the time the events or actions occurred.

Reporting Process Issues

This first part covers issues identified by the Ombudsman related to the reporting process, including how reporters make reports to DHS, and how those reports are received by DHS for purposes of intake. Some of the issues concern what reporters and DHS workers did or did not do, and others relate to DHS policy and the current system and procedure for receiving reports.

Who is Considered a Reporter When Reports Are Relayed from Another Source

DHS administrative rule 441--175.21 (232,235A) defines a “reporter “ as the person making an oral or written statement to the Department alleging child abuse. The definition does not seem to include an individual whose allegation is relayed to DHS by another individual considered to be the reporter. The Ombudsman found several reports which involved relaying of information.



- October 1997 Report from Deb Gosch

Gosch's report in October 1997 was also to relay information from another source who wanted to remain anonymous. At a later time, Gosch inquired to DHS if she needed to file a written report, since she made the report and considered herself a mandatory reporter. A supervisor told her that she did not have to file a written report because she was "a reporter of a reporter." It seemed that in this instance the anonymous informant might have been also considered a reporter.

- December 1999 Report from Karen Roseberry

Roseberry called in December of 1999 to report abuse that she had heard from Dawson and others. Illg told the Ombudsman that one of the reasons for not accepting her report was that she did not have first-hand information.

The Ombudsman finds these contacts illustrate the need to modify current law and DHS policy to clarify who is considered a reporter for purposes of an intake, when the caller is relaying information from another source.

The Ombudsman concludes that the definition of "reporter" does not clearly include an individual whose child abuse allegation is reported to DHS by another individual.

Making Mandatory Reports Directly to DHS

Iowa Code section 232.69 requires mandatory reporters to make a report to DHS if they reasonably suspect a child has been abused. Mandatory reporters are instructed in their required training to make reports of child abuse directly to DHS - - the local DHS offices or the Hotline.

The Ombudsman found at least one instance when mandatory reporters at Small World Child Care Center did not report to DHS a suspected abuse incident.

On September 13, 1999 staff at Small World discovered Shelby's diaper was saturated with blood and contacted a medical clinic on a suspicion of sexual abuse. However, Small World staff did not report this to DHS. Burns explained that she did not call DHS because she did not think she needed to, since she had reported it to Shelby's family doctor, who also was a mandatory reporter.

While it is not known how DHS would have responded to the report, DHS should still have been alerted to Shelby's condition. Had DHS investigated the report and learned that the doctor determined Shelby's condition was due to diaper rash, it would also have been useful for DHS to know that Shelby had a bad case of diaper rash, severe enough to cause lesions that oozed blood. It is possible that DHS may have considered Shelby's condition as possible neglect.

The Ombudsman believes additional effort may be needed to instruct and remind mandatory reporters of the importance and need to report suspected child abuse reports directly to DHS.

Filing of Written Reports by Mandatory Reporters

Iowa Code section 232.70 requires mandatory reporters to file a written report to DHS within 48 hours after making an oral report. Mandatory reporters are told in their required training as mandatory reporter that they are required by law to file a written report.

The Ombudsman found that the owner and an employee of Small World did not file written reports after making oral reports about Shelby to DHS. Linn made a report on February 22, 1999 and Roseberry made reports on September 29 – 30, and October 21, 1999.

In reply to the Ombudsman’s question whether she had a duty to file a written report, Roseberry said she believed the form Illg completed in their presence constituted the written report.

When Chuck came in, he had the forms, and he wrote them out, and I just - I just figured that was the written report, and that Chuck was doing it, so it would be all written in correctly.

Roseberry also added that, whenever they made oral reports to Illg, he did not advise or remind them they also needed to file a separate written report.

The Ombudsman also did not find any written report from Dr. Taylor in follow-up to the oral report he made concerning Shelby on October 21, 1999.

The Ombudsman believes more effort may be needed to instruct and remind mandatory reporters to file a follow-up written report whenever they make an oral report of child abuse to DHS.

- 1999 Consultant Report

Failure to file follow-up written reports by mandatory reporters was also an issue identified by the Child and Family Policy Center (CFPC) and the State Public Policy Group (SPPG), consultants to the Ombudsman in the February 1, 1999 report, “Examination of Fairness and Due Process in Iowa’s Child Protection System.”⁵⁷ The consultants found in their statewide child abuse case record review “that mandatory reporters frequently did not comply with requirements to file written reports.” The consultants learned from focus groups of mandatory reporters that “much of the training that mandatory reporters receive is perfunctory.”⁵⁸

The following recommendations by the consultants, which were communicated to DHS in early 1999, remain relevant and bear repeating and inclusion in this report.

1. Convene working groups of different mandatory reporters (from the health care system, the education system, the treatment system, and the child care system) to identify training needs and “best practices” in providing training and develop means to transfer this

⁵⁷ Consultant Report: “Examination of Fairness and Due Process in Iowa’s Child Protection System Report to the Office of Citizens’ Aide/Ombudsman “ (February 1, 1999), at p. 4.

⁵⁸ Consultant Report (1999), supra, at p. 9.

- information and training to others in the field, and to develop guidelines for coordination between the department and mandatory reporters at the community level.
2. Require that departmental clusters coordinate with major groups of mandatory reporters in their clusters, in order to improve communication and appropriate sharing of information.
 3. Make use of technology, such as the ICN and department websites, to provide additional information and training opportunities for mandatory reporters.
 4. Enforce or reconsider the utility of the 48 hour statutory requirement for the submission of written reports by mandatory reporters or create mechanisms to improve the frequency with which written reports are obtained within 48 hour time frame through departmental reminders and follow-up activities. If the requirement is retained, corrective actions should be developed to improve compliance.
 5. Develop a working group, including the department and providers or their associations (e.g. the Coalition for Family and Children's Services and the Foster and Adoptive Parents Association), to address concerns or disagreements regarding reporting child abuse or subsequent abuse determinations to create an atmosphere where providers will not believe they could be subject to retaliatory action.⁵⁹

Considering Written Reports Before Rejected Decisions

Iowa law requires written reports to be “made” within 48 hours of the oral report. It is possible, under DHS policy and procedure, for supervisors to approve a rejected intake before a mandatory report is received.

The DHS Manual does not clearly indicate what consideration is given to written reports that are filed.

The Ombudsman concludes written reports from mandatory reporters need to be considered in making a determination whether to accept or reject a report.

Problems That Occurred on Calls in the Reporting Process

As discussed in more detail in the “Reporting Process” section, there is no centralized unit or single point of contact for the receipt of child abuse reports. Under the current system, persons calling to report abuse during the normal business hours to the Hotline, the Registry office, or a local DHS office have to be routed to the appropriate intake worker. How a call is routed and who does the intake depends on local policies and procedures. Generally, the person initially answering a call determines if the caller wants to report abuse - - this is done because people can be calling for different reasons, especially to the local DHS offices. Once that person determines the call is to report abuse, he or she immediately directs the reporter to the worker responsible for intake or has the intake worker contact the reporter. In the case of after-hours calls to the

⁵⁹ Consultant Report (1999), supra, at p. 10.

Hotline, the person answering the Hotline immediately pages the on-call intake worker, who then tries to call the reporter.

The Ombudsman identified problems in the way some calls concerning Shelby were received and handled under this process, before the calls even reached the intake phase.

Caller's Information Left on Telephone/Voice Mail

- October 21, 1999 Report from Karen Roseberry

When Roseberry called to report Shelby's swollen hand on October 21, 1999, she tried to contact Illg directly. Roseberry explained she called Illg directly because she learned, from calling the Hotline and the Dickinson County DHS Office, that her calls routinely ended up being handled out of the Clay County DHS Office, and more specifically by Illg.

You call this hotline, and this hotline circles around and it comes back to Chuck Illg's office. You call the Department of Human Services. And it just circles around and it comes around here to Chuck Illg's office. Everything for mandatory reporting on any abuse things comes out of Chuck Illg's office.

So if you have a problem communicating or whatever with this one person, there is no place else that you can go because everything circles right around here to this one individual.

As discussed in the chronology, the Ombudsman determined that Roseberry could not reach Illg and left three messages on his voice mail. As it turned out, Illg did not talk with Roseberry until about four hours later, which resulted in a delayed response to Shelby's injuries.

Illg expressed general frustration to the Ombudsman about receiving reports on voice mail.

Do you know how nice it would be in our office if somebody sat by the phone and all they did was take child abuse intakes, and they gave them to the supervisor, and the supervisor said accepted or rejected? If I never had to worry about that, that would be awesome ...instead, we're out here. We get back to the office, [someone] ... leaves it on ... voice mail, and I get it at six o'clock at night.... But this has happened to me, and I will tell you it's more than once.

December 21, 1999 Contact From Kristy Linn

Linn, like Roseberry, said she usually tried to contact Illg when she wanted to report abuse. However, he was not available when she called in mid-December, 1999, to report injuries Sherry Dawson had observed on Shelby. Linn then called to speak with Slawson, his immediate supervisor, but she was on vacation, so she ended up leaving a voice mail message for Heckenlively, to call her back. As discussed in the chronology, the Ombudsman was unable to determine if Linn's message indicated she was calling about an "abused child," as she claimed. Heckenlively did try to call Linn back three times, but was unable to reach her. Linn was left with the impression that no one called her back.

The Ombudsman is not able to determine if Linn informed the receptionist the reason for her calls or if she simply asked to speak with Illg and then with his superior. Had Linn been able to connect directly with an intake worker, at least her report would have been heard and considered.

Caller's Information Not Treated as a Report of Child Abuse

- December 22, 1999 Contact From Rev. Donald Dressel

Rev. Dressel called the Clay County DHS Office on December 22, 1999 wanting to make a child abuse report. The Ombudsman does not know what he actually reported to the receptionist who took the call. The receptionist gave a message to Illg indicating that Rev. Dressel had called with concerns about a child. Illg did not consider Rev. Dressel's call to be a child abuse report, because he assumed the receptionist had determined that Rev. Dressel was not reporting abuse. Consequently, the limited effort – one call and message - he made to contact Rev. Dressel was not done with an intake in mind.

- December 1999 Contact From Beth Will

Similarly, Will called the Dickinson County DHS Office in December 1999 to relay what Rev. Dressel had told her. The receptionist transferred her call to Nelson, a social worker who was also Case Manager for Shelby's case. Again, the Ombudsman does not know what Will specifically told the receptionist or Nelson. Nelson considered in her February 8, 2000 email, the call only to be "expressing concern" and therefore did not relay it to an intake worker as a child abuse report.

Caller Not Contacted Promptly for an Intake on the Report

- September 29, 1999 Report from Karen Roseberry

Roseberry made a report concerning Shelby during a September 29, 1999 conversation with Stoever, a DHS licensing consultant, concerning the status of Small World's childcare license. Stoever immediately relayed the information to Illg. The information was clearly a report of child abuse. Illg did not talk to Roseberry until 24 hours later.

Illg explained that he believed he had until the end of the next working day to notify the reporter whether the report was accepted or rejected. But, Illg only knew what Stoever relayed to him; he had not yet spoken with Roseberry, the reporter. In fact, he did not decide to reject her report until he had spoken with her and determined she had changed her story.

- December 12, 1999 Report from Sherry Dawson

Dawson made a report in the evening of December 12, 1999, but did not speak to a CPW for an intake until the following morning. As discussed in the chronology, the Ombudsman determined that the Hotline worker paged Morey, the on-call CPW, but Morey did not call Dawson, as she should have under DHS policy and procedure. The Ombudsman believes Morey knew Illg had recently done an assessment concerning Shelby's family, and consequently informed him about the report. Illg then contacted Dawson to complete the intake.

Hotline Documentation Not Provided to Intake Worker

- December 12, 1999 Report From Sherry Dawson

The Ombudsman discovered an aspect in the reporting process that may have impacted how DHS responded to Dawson's report on December 12, 1999. The DHS employee handling Hotline calls at the State Training School that evening had documented what Dawson reported onto a Contact Report, but that record was never provided to the intake worker responsible for determining whether to accept or reject the report.

Although the Contact Report form had been developed by a former DHS official for use by Hotline workers after-hours, DHS had no written policy regarding its use or retention. In fact, Armstrong, Chief, Bureau of Protective Services, did not know that completed Contact Reports were sent to and filed in his office. He became aware of it after the Ombudsman learned of the existence of the Contact Reports from the State Training School and requested a copy from his office.

[*Note:* Armstrong informed the Ombudsman that DHS has since changed its practice and now faxes copies of completed child abuse Contact Reports to the appropriate local DHS offices.]

The crucial fact is, as the Contact Report documented, DHS did receive a report from Dawson, which alleged injuries to Shelby that had not been investigated and which alleged that Watkins' paramour, Jesse, was the abuser and was residing in Watkins' home. Dawson's report clearly met the criteria for assessment.

Illg said he did not receive the same information from Dawson when he spoke with her on intake the following day. The Ombudsman wonders what might have happened on Dawson's report. Had Illg been provided a copy of the Contact Report as part of his intake before the report could be rejected, he may have responded differently.

Problems Related to Policy and Practice

Of significant concern to the Ombudsman was the practice of DHS employees, who were not intake workers, making determinations whether a call they received concerning a child is a report of child abuse. At least in two instances, Rev. Dressel's December 22, 1999 call and Will's call, the reporters were calling about suspected abuse, but their calls were not considered reports of child abuse, just calls expressing "concerns." The Ombudsman is concerned for several reasons that such decisions or distinctions may be screening out calls from the intake process.

First, the Ombudsman believes the definition of a "report of child abuse" should be interpreted broadly in furtherance of the stated purpose under Iowa Code section 232.67 to "provide the greatest possible protection to victims or potential victims of abuse." A "report of child abuse" is defined by DHS rule as a "verbal or written statement made to the department by a person who suspects that child abuse has occurred."⁶⁰ The key is whether the reporter indicates he or she suspects a child has been abused, not whether what the reporter is saying necessarily meets the definition of child abuse. Probably most reporters, especially permissive reporters, are not going to know the legal definition of child abuse.

⁶⁰ 441 I.A.C. 175.21(232,235A).

Second, the Ombudsman believes it is the responsibility of the intake worker to decide whether what someone is reporting constitutes child abuse. That worker is the person trained, experienced, and responsible to make that decision. The Ombudsman recognizes that workers who answer or route calls from reporters also field a variety of calls about children, and it may be difficult in some instances to distinguish if a call is to report abuse or for some other purpose.

Furthermore, having the intake worker make that decision triggers additional steps to assure the protection of a child. Even if the worker determines that a report does not meet the criteria for an assessment, the worker can refer it to law enforcement for investigation (if it was alleged the child was abused by someone other than a caretaker), or to DHS or elsewhere for services, if appropriate. In addition, any rejection decision by an intake worker goes to a supervisor for final approval. Furthermore, all final rejection decisions are sent to the county attorney for review.

[*Note:* DHS has implemented some recent changes related to child protection. On September 8, 2000 Governor Thomas Vilsack issued a press release, indicating that he had met with Jessie Rasmussen, Director of DHS, regarding a new child protection policy, for which the watch phrase is: "When there is a doubt, work to take the child out." In a letter to all DHS staff dated September 18, 2000, Rasmussen clarified one of the steps under the new policy is as follows:

If you receive information that raises concerns about the care of a child, immediately relay the information to your child protection unit. The child protection unit shall then treat that information as a report of child abuse.]

The Ombudsman agrees with this clarification or directive from Rasmussen.

A related issue is whether intake workers are required or expected to contact the reporter after being informed about the report and how quickly that should occur. Roseberry made a report on September 29, 1999 and Dawson made a report on December 12, 1999, but neither of them spoke with an intake worker until the following day. In each instance, the DHS worker who answered the call initially informed the reporter that an intake worker would be notified immediately to contact the reporter. The Ombudsman found no reasonable explanation for the intake worker's delay in contacting the reporter.

The DHS Manual does not clearly state that intake workers must contact a reporter as soon as possible after being informed about a reporter's call.

The Ombudsman believes the intake worker - - whoever is designated or responsible for gathering report information and deciding whether to accept or reject the report - - should speak with the person making a report as soon as possible. Intake workers are the persons who are trained, experienced, and responsible for gathering information; they should not just rely on messages or information relayed by other DHS employees in making crucial intake decisions.

Furthermore, if a reporter is not immediately connected to an intake worker when the reporter calls, the Ombudsman believes an intake worker should try to contact the reporter as soon as possible. Of course, if the message or information requires a CPW to take immediate action for the protection of a child, that action should take precedence.

Problems Related to System

Under the current system:

- Reporters have a difficult time understanding DHS's process for receiving reports, especially since it varies depending on where the call is made (Hotline, Registry, or county office), when it is made (during or after business hours), and which county the call is directed to. Reporters may unknowingly circumvent the protocol that local offices have set up for receiving reports, by trying to call a certain worker every time or by leaving a message on a worker's voice mail.
- Reporters often have to talk with more than one DHS employee before reaching an intake worker. This means reporters may have to repeat why they are calling and what they are reporting. This can be frustrating and confusing to a reporter, who most likely wants to be able to tell someone right away what he or she knows. In addition, when callers speak with multiple employees, the potential exists that what a reporter tells the first employee may inadvertently not be the same or as complete as what is told to a subsequent employee or the intake worker.
- Each time a DHS employee speaks with the reporter, the employee finds out the purpose for the call. As discussed above, in some instances employees determined that some calls were not reports of child abuse (i.e., merely concerns), and consequently did not refer them on to an intake worker.
- Sometimes reporters have to await a return call from an intake worker. This again can be frustrating, especially when the call is not returned immediately or never returned, for whatever reason, whether it is due to an oversight by the worker or difficulty in reaching the reporter.
- Some notes or other documentation by DHS employees or contract workers (e.g., American Red Cross staff who handle after-hours calls for the Des Moines region) who answer calls are not always provided to the intake worker, nor made an official part of the intake record.

The Ombudsman concludes improvements should be made to the current system for receiving child abuse reports to better assure the efficient and effective referral of those reports to the intake process.

One of the stated purposes of Iowa's protection system is to promote or encourage the reporting of suspected cases of abuse. To facilitate that, the Ombudsman believes Iowa's child reporting system should be redesigned so that reporters can:

1. Have a single point of contact which they can be instructed to call regardless of where they live, what time of day it is, or what county will follow up;

2. Speak with an intake worker in the first call and not be routed through multiple transfers, or have to await a return call; further, that they not have to repeatedly state why they are calling and what they want to report;
3. Be assured the information they report will be properly documented and thoroughly considered. To that end, any report information provided by a reporter to any DHS worker should be documented and become part of the intake record, to be considered during the intake process. Furthermore, the record should be documented and retained for the time period provided by law, and be accessible to staff who may need the information in the performance of their responsibilities.

The Ombudsman believes such a system would also help address or greatly reduce the practice problems the Ombudsman identified.

Intake Process Issues

This part focuses on issues related to the intake process. The issues include what reports were handled and documented as intakes, how well the intakes were documented, whether appropriate decisions were made on the reports, and whether reporters were notified of the decisions.

Documenting Reports as Intakes

Reports Concerning Shelby

The Ombudsman could not determine whether Illg documented the October 1997 reports from Gosch and Phelps, because any rejected intakes completed would have been destroyed by the time of the Ombudsman's investigation. However, the Ombudsman found that Roseberry's September 1999 report and Dawson's December 1999 report were not documented as intakes.

Illg acknowledged that he should have documented Roseberry's report as a rejected intake. He did not complete an Intake form on Dawson's report because he did not consider the information she reported to be allegations of new injuries nor allegations of sexual abuse. He acknowledged the contacts from Dawson should have been documented.

The purpose of intake is to gather and document information from a reporter, and then determine and document the worker's determination and disposition. Roseberry (at least initially) and Dawson were reporting what they suspected to be child abuse, and therefore should have been treated as reports of child abuse.

The Ombudsman concludes Roseberry's September 1999 report and Dawson's December 1999 report should have been handled and documented as intakes.

Reports Generally

What happened in these situations is indicative of a larger problem the Ombudsman discovered in the investigation. Just as DHS employees do not always refer contacts concerning a child to intake workers as reports of child abuse, intake workers likewise do not always document every contact they received concerning a child as an intake. Some intake workers may not document a contact, if the worker did not consider the caller's information to be an allegation of abuse.

Steven Hayward, Sioux City Regional Protective Service Program Specialist, stated he does not believe every call must be documented. He pointed out that CPWs are in a "very visible position," and therefore they receive many calls that may be simply to request information or that may not be case specific. Vern Armstrong, Chief of the Bureau of Protective Services, told the Ombudsman that all contacts received by an intake worker that expressed concerns about a child should be documented, as a rejected intake, as a service referral, or in an Assessment Summary, if one is still opened.

The Ombudsman believes it may be overly broad to require a CPW or other person designated to do intakes to document all contacts they receive as an intake. For the same reasons discussed previously, the Ombudsman believes that any contact from a caller with concerns or suspicions about the condition of a particular child or the care provided to the child should be handled as a report of child abuse and be documented as an intake. The worker can then determine and document whether the intake should be rejected, accepted, or referred elsewhere. If it is rejected, it is subject to approval by a supervisor and review by the county attorney, which serve as added safeguards to ensure the child is adequately protected.

The Ombudsman identified a more specific policy issue regarding how to document a report that is rejected while there is still an open assessment about the same child. The Ombudsman discovered different opinions among DHS employees. Workers in the Clay County DHS Office said their practice was to include the rejected report information in the Assessment Summary, regardless if it was a duplicate of the report being assessed or if it did not meet the criteria for assessment. Armstrong believed any additional or new reported information that does not meet the criteria for assessment should be documented as a rejected intake or in the Assessment Summary.

The Ombudsman believes that all reports that are rejected should be documented as rejected intakes, even if there is an opened assessment on the same child. That includes any report that is determined to be a duplicate of a report already being assessed. That will enable a supervisor to do a more immediate review of the rejected intake, to determine if the rejection was appropriate, rather than waiting until the Assessment Summary is completed. However, the Ombudsman also believes that a report that is rejected because it is duplicative should also be documented as other relevant information in the Assessment Summary. Such documentation will provide a more complete and enduring record of the contacts related to that assessment.

Descriptions of Abuse Allegations

As just discussed, there is no intake record on some of the reports made concerning Shelby. The Ombudsman did review those intakes for which there is a record. Following are the descriptions of the alleged abuse concerning Shelby as recorded on the Intake forms.

- February 2, 1999 report: “Reporter states that Shelby has a black eye. Reporter states that there is questionable bruising around the eye.”
- October 21, 1999 report: “Reporter states that Shelby has numerous suspicious injuries.”
- December 2, 1999 report: “Reporter states that Shelby has a cigarette burn on her stomach. Reporter also states that Shelby has bruising on her face and a possible broken nose.”

The Ombudsman does not know what efforts Illg made to obtain more detailed descriptions from the reporters. The Ombudsman is cognizant that reporters sometimes may have difficulty recalling or describing details.

Inflicted bruises may be distinguished from accidental bruises by several characteristics, including their location, their number, and relative ages. Therefore, it is important to describe accurately the location, size, shape, and color of each bruise, as well as the presence of any tenderness and/or swelling. Bruises located on more padded areas, like cheeks, or more protected areas are highly suspicious. Black eyes are also suspicious when they are bilateral or if they are attributed to falls when evidence of trauma to the nose or superior orbital ridge is lacking. Linear bruises alternating with clear, spared areas may be the result of forceful slapping with an open hand. Although it is difficult to determine the age of a bruise by its color, the color nevertheless may help determine whether it is an older versus a more recent bruise, since bruises progress through a succession of colors.⁶¹

The DHS Manual states that an intake worker’s ability to gather information regarding a report of child abuse “is critical to the assessment process and is the first step taken to initiate safeguards for children at risk.” It adds that one of the advantages of a thorough intake is “more complete information at the outset for the assigned worker....” However, the DHS Manual and the Intake form do not give clear directive how thoroughly intake workers should describe the alleged injuries.

The Ombudsman believes it is important that the reported injuries, including the characteristics of any bruises, be described as completely and precisely as possible on the Intake form. The information will be helpful to the supervisor who is making the final decision to reject a report, or the CPW who is assigned to do the assessment.

Intake Decisions on Reports

As discussed in the “Intake Process” section, the DHS Manual states that a report must include

⁶¹ Richardson AC, “Cutaneous Manifestations of Abuse.” *Child Abuse Medical Diagnosis and Management*, Reece RM, ed. Philadelphia: Lea & Febiger; 1994: p. 170.

some information indicating the following, before it can result in an assessment:

- The alleged abuse occurred to a child.
- The alleged abuse was caused by the acts or omissions of a person responsible for the care of the child.
- The alleged abuse falls within the definition of child abuse.

The DHS Manual also states that the intake worker “must obtain sufficient information to be able to determine that abuse has *not* happened before rejecting a referral.”⁶²

It also provides that it is “possible to make reasonable inferences that would cause a case to be accepted for assessment based upon descriptions of certain abusive activities.”

From his testimony to the Ombudsman, it appears Armstrong believes that intake workers should consider from the information gathered, if they “can make a reasonable inference that child abuse may have occurred.” He said that factors that should be considered in making a reasonable inference include the age of the child, the type of injury, abilities of children at various ages, and mobility of a child.

Tony Montoya, the Bureau’s Child Protective Services Program Manager, told the Ombudsman he believes “any injury which raises concerns about the mechanics of how that injury occurred would be sufficient to consider us for accepting that.” He said DHS “wants to be sure that questions are asked at that intake so as to discourage over intrusiveness in a family by the department but at the same time are protective of children. His opinion is that the DHS Manual has an “undercurrent communication that when we have doubt, we should be looking into situations. So if somebody can’t be positive or conclusive that it’s accidental, then we should be looking at it....”

Hayward, a regional program specialist, stated DHS “cannot trigger a child abuse assessment simply because a child has an injury.” He said there needs to be something suspicious about the injury such as a “reasonable belief that this was an inflicted injury.”

Reports Concerning Shelby

- October 1997 Reports from Deb Gosch and Terri Phelps

The Ombudsman found from the evidence that Illg received similar reports from Gosch and Phelps in October 1997, in which they alleged at least one incident when Watkins left her children alone in the home during the night. At that time, Shelby was six to seven months old and [] was six years old.

⁶² DHS Manual, *supra*, at p. 23. This statement has been replaced with the following language in the DHS Manual, as revised January 11, 2000: “The intake worker must obtain sufficient information to be able to determine if the intake criteria have been met.” However, the current DHS Manual also adds the following statement with respect to allegations of physical abuse: “Accept the report for assessment unless there is no doubt that the injury was accidental.”

This incident was very similar to the following example of an abusive situation that is contained in the DHS Manual:

A reporter indicates that a six-year-old is left to care for her two-year-old brother while parents work. You may reasonably infer that children this young may be incapable of self-supervision, even in the absence of reported harm.

The Ombudsman believes Illg could have reasonably inferred that [] and Shelby were not capable of supervising and caring for themselves. The Ombudsman concludes Illg should not have rejected the October 1997 reports from Gosch and Phelps and should have initiated an investigation for possible denial of critical care.

- September 1999 Report from Roseberry

Roseberry made a report on September 29, 1999 to Stoever, a DHS childcare license consultant, in which she described several injuries to Shelby's face, including "grab marks" on her jaw. Stoever relayed the information to Illg. Illg said Roseberry changed her story when he spoke with her the following day. According to him, Roseberry no longer suspected Shelby had been abused and believed Watkins' explanation that Shelby had fallen off the couch. Illg therefore rejected the report.

The Ombudsman is unable to determine if Roseberry's report changed as Illg claimed, and therefore makes no conclusion whether Illg should have rejected her report. However, the Ombudsman believes there were a couple of steps Illg should have taken before rejecting the report.

First, Illg should have made his own independent decision whether the injuries were suspicious for abuse, instead of relying on what Roseberry believed may be a plausible explanation from Watkins. An article about manifestations of abuse states the following: "Grab or pinch marks are bruises produced by the tips of the fingers as force is applied."⁶³ If there were "grab marks," that could perhaps have created a degree of suspicion sufficient to open an assessment.

Second, Illg should have undertaken a more in-depth intake, by contacting other mandatory reporters at Small World to find out what they knew about Shelby's injuries.

- December 1999 Report from Sherry Dawson

The most critical rejection decision by DHS occurred on December 13, 1999 to a report from Dawson. As discussed previously, the report documented by Christensen clearly met the criteria to open an assessment.

As explained in the chronology, the Ombudsman found Illg received almost the same description of injuries from Dawson, which was: two black eyes (black in color), a bruise or contusion on her forehead, swollen eyes and face, and sores and redness in her vaginal area.

⁶³ Richardson AC, "Cutaneous Manifestations of Abuse," supra, at p. 170.

Illg said he did not accept the report for two reasons: 1) He believed the black eyes and bruise on the forehead were the same injuries he had already investigated on December 3, 1999; 2) He did not believe Dawson was alleging the sores and redness were caused by sexual abuse, but by diaper rash.

It is the Ombudsman's opinion that Illg received information from Dawson sufficient to initiate an assessment on her report.

- Dawson reported to Illg injuries that he had not previously investigated.

Dawson told him about facial swelling that was not present when he observed Shelby on December 3, 1999. In his unsent December 29, 1999 letter to Bjornstad, Illg said that he had received "concerns that Shelby eyes and face were swollen." Illg acknowledged to the Ombudsman that he was referring to concerns he had heard from Dawson.

Furthermore, Dawson reported a bruise or contusion on Shelby's forehead that Illg had not noted before. It was not mentioned in his Assessment Summary.

- Illg could have reasonably inferred that Shelby's black eyes were new and more recent injuries than what he observed on December 3, 1999.

When Illg dictated his Assessment Summary the morning of December 13, 1999, he described that the bruising he saw underneath both eyes on December 3, 1999 had already "faded very quickly."

Two individuals who testified they saw Shelby the afternoon she allegedly injured herself substantiate Illg's assumption that the bruising was going away. Both of them observed bruises that were already turning yellow.

Although recent studies have shown determining the age of bruises by color is imprecise, they agree that bruises go through a succession of colors - - initially appearing red, purple, black, or blue, and then becoming green, yellow, and possibly brown before clearing. Yellow coloring is a reliable sign of an older bruise.⁶⁴ This was also the explanation provided by Dr. Shah.

Illg acknowledged that what Dawson described were eyes that were darker and more discolored than what he had seen ten days earlier. He also acknowledged she reported that she saw black eyes the evening before he spoke with her.

If Illg's impression was that the bruises were fading quickly back on December 3, 1999, it would have been reasonable for him to infer that the black eyes Dawson saw on December 12, 1999 were from a new injury. Furthermore, given the color

⁶⁴ Schwartz AJ, Ricci LR: "How accurately can Bruises be aged in abused children? Literature review and synthesis." *Pediatrics*. 1996 Feb. 97(2): pp. 254 - 7.

succession of bruises, it would not have been possible for the discoloration Illg saw beneath Shelby's eyes to become black or get darker *again*.

- Black eyes are suspicious for physical abuse when they are bilateral or if they are attributed to falls when evidence of trauma to the nose or superior orbital ridge is lacking.⁶⁵

It is also the Ombudsman's opinion that there was sufficient information for Illg to infer that the redness and sores on Shelby's vaginal area could be the result of sexual abuse or denial of critical care.

- As discussed in the chronology, the Ombudsman found Dawson told Illg that she suspected that the sores and redness in Shelby's vaginal area were due to sexual abuse. Dr. Shah told the Ombudsman that child protection workers should be especially concerned when blistering lesions are present in the vaginal area, because that may be indicative of sexually transmitted diseases.
- Illg attributed the cause to diaper rash, without any real basis to do so. There is no evidence he was even aware that Shelby had a prior problem with diaper rash nor how severe or chronic a problem it was. He had not observed any similar conditions nor investigated them previously, nor had he seen Shelby's medical records regarding treatment she received for diaper rash. Even assuming he knew about Shelby's past problem with diaper rash, the fact that it was reoccurring and was severe enough to cause sores or lesions should have created a suspicion of child neglect (i.e., denial of critical care).

The Ombudsman concludes that Illg should not have rejected Dawson's report and instead should have completed an assessment on the reported injuries for possible physical abuse, sexual abuse, or denial of critical care.

[Even allowing that Illg could have reasonably assumed that Shelby's black eyes and forehead bruise were the same injuries as seen on December 3, 1999, it is the Ombudsman's opinion that this and other information Illg subsequently received warranted further evaluation of the injuries. This is discussed in more detail later under "Assessment Process Issues."]

Reports Generally

The Ombudsman found a problem with consistency among intake workers in making decisions whether to accept or reject a report. Illg pointed out to the Ombudsman that the "policy of rejected intakes is a mess.... If you interview ten supervisors, they all may tell you that they reject different things for different reasons." Armstrong perceived that there is a "variance about the perception of what an injury may be and how it would be handled." He also acknowledged

⁶⁵ Richardson AC, "Cutaneous Manifestations of Abuse," *supra*, at p. 170.

some counties or areas may reject a report that does not allege that the injury was caused by a caretaker or the omission of the caretaker.

The Ombudsman believes a factor for this inconsistency is lack of clarity in the DHS Manual. For example, workers are told by one provision that the report must have “some information” to indicate a caretaker was responsible for the alleged abuse before they can initiate an assessment. But, they are also told they must have “sufficient information” to indicate that abuse did not occur before they can reject a report. When read together, these statements may create some confusion or ambiguity in some situations. There may be some reports which lack information to indicate a caretaker was responsible for the alleged injury, but also lack sufficient information to indicate abuse did not occur. It may not be clear to an intake worker if such reports should be accepted or rejected.

[*Note:* Another change announced by DHS Director Rasmussen in her September 18, 2000 letter to DHS staff states the following with respect to making decisions on intakes:

When making a decision about whether an intake should be accepted for assessment, and if you cannot rule out abuse, initiate an assessment. If you are in doubt, initiate an assessment. If, in your professional judgment, the circumstances surrounding an intake raise questions about a child’s safety but do not meet the requirements for opening a child abuse assessment, be aggressive in finding a way to intervene on the child’s behalf. This could include making a service referral, consulting with the county attorney regarding an ex parte order, or referring the matter to law enforcement.]

Implementation of the above clarification or directive from Rasmussen may help to address the problem of inappropriate or inconsistent decision-making during the intake process. The Ombudsman also believes it would be helpful to modify the DHS Manual to remove any ambiguity regarding the criteria or required information for acceptance or rejection of a report. Furthermore, the Ombudsman believes that additional training on how to make intake decisions, including what factors to consider and what is meant by “reasonable inferences,” could also be helpful. Having a specially trained group of workers whose primary responsibility is to conduct intakes and make intake decisions would also lend to consistency.

- 1999 Consultant Report

Again, the 1999 Consultant’s Report by CFPC and SPPG made findings and recommendations about “intake screening” of child abuse reports, especially those which are rejected, which remain relevant and support what the Ombudsman found regarding documentation of intakes and rejected decisions. Their findings and recommendations were:

Findings. The child protection system conducts an initial screening, at which time certain reports are rejected or screened out and no assessment is conducted. Case record reviews found that information about the reports that was screened out was routinely missing in the records. In many instances, it was not possible to determine from the records why the report was rejected for further assessment. Even when a reason for the rejection was given, it frequently was generic and did not provide any case-specific

detail. There was wide variation across clusters with regard to the thoroughness of case record rejection verification. One cluster, for instance, had very clear and complete information on screened out reports, demonstrating that it is possible to complete such documentation even when cases are quickly screened out. In addition to documentation, the level of actual supervisory oversight and involvement was unclear. In the focus groups, some mandatory reporters indicated that there were significant worker-to-worker differences in whether reports were screened out or accepted for assessment. These findings speak to issues of fairness and consistency in practice for the screening process, and to questions about under-investigating as well as over-investigating child protection cases in general.

Recommendations.

1. Enforce the completion of the intake form for all rejected reports, including clear and case-specific documentation of the reasons for the rejection. Implement corrective action measures in those areas where information is not completed on the existing forms that are currently used.
2. Develop a system to insure the enforcement of the requirement of supervisory review of all rejected reports to insure their completeness and increase greater consistency of decision-making at this point in the child protection assessment process.
3. Over the next year, develop more specific guidelines for rejecting cases that are based upon existing best practices.
4. Make reviews of screened out cases a prominent part of the monitoring and quality assurance process. Conduct a subsequent review of rejected cases (some time after the above recommendations have been implemented) to determine whether there is consistency in the application of policy regarding decisions to reject cases.⁶⁶

[*Note:* As of April 1, 2000 all intakes are entered into the DHS computer system; the supervisor reviews and approves, by electronic signature, whether to accept or reject the intakes.]

Notifying Reporters of Intake Decision

DHS policy provides that when the rejection decision is made, the supervisor or designee shall make reasonable efforts to notify the reporter of the rejection decision, unless this was done during the initial intake. There is no requirement that the notice be done in writing. DHS policy does say to document that the reporter was notified of the rejection.

The Sioux City Region's policy provides it is "the responsibility of the Protective Services Worker to notify all reporter(s) whether or not a referral meets legal criteria for Assessment/Evaluation."

Due to the unavailability of supporting documentary evidence, the Ombudsman was unable to determine whether Illg notified Gosch or Phelps that their October 1997 reports were rejected.

⁶⁶ Consultant Report (1999), *supra*, at p. 4.

The Ombudsman found that Illg did not clearly inform Dawson whether her report had been accepted or rejected. This contributed to her repeated calls to find out what was happening on her report. Illg said that he could not tell her that he had already received the same report and was investigating it because that would be breaking confidentiality.

From communications with different supervisory and program staff, the Ombudsman believes that it is unsettled within DHS whether it is a violation of confidentiality laws to merely inform a reporter that the report is being rejected because it is a duplicate of a prior report. In view of that, the Ombudsman cannot conclude whether Illg violated policy in not notifying Dawson of the reason for rejecting her report.

However, the Ombudsman believes that a reporter should be informed of that reason for rejection, if at all possible. Otherwise, the reporter may be left in limbo as to what is happening on the report or why the report is being rejected. In addition, the reporter may mistakenly assume that DHS did not consider the reported information to be indicative of child abuse and may not report similar incidents in the future.

[*Note:* A new law went into effect April 21, 2000, requiring DHS to inform reporters “orally or by other appropriate means” within 24 hours of the report, whether or not DHS has initiated an assessment.⁶⁷ In response to the new law, DHS has implemented a new policy regarding notification of intake decisions. “Manual Letter No.16-E-1,” issued on September 12, 2000, provides that reporters be given oral notice of the intake decision within 24 hours, followed by written notice within five working days.]

The Ombudsman agrees with DHS’s new policy, that in addition to any oral notice, written notice should be given to all reporters whether the report was rejected or accepted for assessment, or referred for services.

The Ombudsman believes that any written notice should clearly explain the reason for any rejection, and should also indicate what a reporter can do if the reporter disagrees with the decision or has additional questions about the decision.

The Ombudsman also believes that DHS policy should clarify what reason should be provided to a permissive reporter if the report is rejected because it is considered a “duplicate” of a prior report.

Assessment Process Issues

This part discusses policy and practice issues related to investigations or assessments that were completed prior to Shelby’s death. It also discusses the review done on completed assessments. In addition, the Ombudsman examines referral of recommended services, and the availability and use of other resources in assessments, including multi-disciplinary teams and child protection centers.

⁶⁷ 2000 Iowa Acts, House File 2377, section 4.

Completed Assessments

The Ombudsman identified a number of policy and practice problems concerning how the investigations and assessments were conducted and documented. The majority are practice problems - - actions the Ombudsman believes the CPW reasonably should have taken, as provided by DHS policy, to determine if Shelby had been abused and to evaluate her family and home situation.

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Incident # 1999060032 (February 22 – March 22, 1999)

Illg received a report from Linn at Small World that Shelby had a “black eye” and “questionable bruising around the eye.” He took photographs of Shelby’s injuries. He also interviewed Linn, Watkins, and [] Watkins explained one of Shelby’s playmates told her that Shelby ran into her bedroom doorframe while chasing each other around the house. She said she heard Shelby crying, but did not witness the incident.

- The playmates or their parents were not interviewed to verify the playmates’ presence at Watkins’ home and the explanation given by Watkins for the injuries.

The Ombudsman learned from Watkins' trial testimony that she was not home at the time of the incident and that she heard about the incident from a babysitter.

- Illg did not completely and accurately describe the bruises on Shelby's face. In the Assessment Summary, he described a "faint" nickel size bruise on her left cheek and "discoloration underneath [her] eye." He did not note any linear bruises.

Use of the terms "discoloration" or "faint" do not adequately describe the color of the bruise.

Small World staff testified to having seen marks which suggested they had been inflicted by a human hand. From examination of the photographs Illg took, both the Ombudsman and Dr. Shah discerned two linear bruises.

As discussed previously, various characteristics of a bruise -- location, size, shape, and color -- may be helpful in determining whether it was accidental or intentionally inflicted. Therefore, it is important to describe the bruise as precisely and accurately as possible.

Furthermore, examination of the bruises must be done in consideration of the explanation or history given for the injury (mechanism of injury).⁶⁸

- Illg did not closely examine and measure the grooves or notches on the doorframe to determine if they matched the bruises on Shelby's cheek.

Dr. Shah told the Ombudsman that, had she been consulted by DHS on the photographs, she would have advised the worker to measure the breadth of the doorframe and compare it with the linear bruises to see if they matched.

- Linn told Illg that Watkins had a new boyfriend and suggested a possible connection between the boyfriend and Shelby's change in behavior. However, Illg did not follow-up by asking Watkins to identify the boyfriend, or inquire with any other individuals further to find out about the boyfriend's relationship with Watkins and her children. Furthermore, he did not verify with other Small World staff whether there had been a change in Shelby's behavior and whether any change might be suggestive of abuse.

⁶⁸ Richardson AC, "Cutaneous Manifestations of Abuse," supra, at pp. 170 - 171 .

Incident # 1999300043 (October 21 – November 18, 1999)

According to the Intake form, the reporter stated that “Shelby has numerous suspicious injuries.” After observing Shelby, Illg identified the following injuries: a very swollen thumb and wrist on her right hand; a scratch below her right ear; two red marks, which appeared to be bruises, underneath her right eye; several bruises, approximately the size of a dime and greenish in color, on her back; fourth toe on the left foot was covered in blood and looked very sore.

He asked Watkins to take Shelby to her family doctor or the hospital emergency room. Dr. Taylor, who examined Shelby, determined the second metacarpal in her right hand was fractured.

Watkins told Illg she did not know exactly how Shelby sustained the fractured hand, the bruises on her back, the scratch on her ear, or the injured toe. She speculated that Shelby injured her hand from falling out of her crib, incurred the bruises at Small World from children picking her up, and stubbed her toe on a piece of furniture.

- Illg interviewed Watkins, , and Dr. Taylor. He did not interview regarding Shelby’s injuries.
- Although Illg requested Watkins take Shelby to a doctor, he did not speak with the doctor until the following day, *after* the doctor had examined Shelby.

It is not clear whether a CPW needs to contact the doctor in advance, under the following provision in the DHS Manual:

If you refer a child to a physician for an examination or test, contact the physician for results of the examination or test within 24 hours of making the referral....

Make any medical or other professionals contacted for consultation aware of the explanation the subjects of the report have given for the injury. Ask the professional consulted if the injury is consistent with the explanation.

Armstrong agreed the policy is ambiguous, but believed the CPW should contact the doctor before the examination. He said the CPW should provide the following information: the

alleged injury; possible explanations for the injury that have been provided; any other history the CPW believes would be helpful. He acknowledged some workers are concerned that a contact before an examination may bias or pre-dispose the doctor regarding the cause of the injury. Nevertheless, he believes providing the information to the doctor may help in protection of the child and therefore outweighs any bias.

Montoya said the best practice is to make the prior contact as it would help provide the doctor with information in preparation for the examination, but he did not believe it was necessary in every instance.

Dr. Taylor told the Ombudsman that his approach to the examination would have been “much different” had he been contacted in advance. It meant that he would have asked more probing or different questions or conducted other diagnostic tests. It did not necessarily mean that he would have formed a preconceived notion whether abuse had occurred.

The Ombudsman concludes that it would be beneficial for a CPW to contact the doctor in advance of an examination, to apprise the doctor regarding the injury and the explanation that has been given for the injury, and any other relevant history.

- Illg misidentified Shelby’s fractured hand throughout the Assessment Summary as a “broken wrist.”

Illg explained to the Ombudsman he believed Dr. Taylor referred to it as a wrist injury. However, the evidence does not support that. By the time Dr. Taylor spoke with Illg, he knew it was a fractured metacarpal. Dr. Taylor’s own progress notes, dated October 21, 1999, identified the injury as a fractured metacarpal. There is no reference to any wrist injury in his notes or any of the hospital medical records.

Illg’s misperception or misunderstanding of the precise injury likely affected his investigation and determination whether the injury was inflicted or accidental. As noted by Dr. Shah, falling out of a crib is a much more believable explanation for a broken wrist than for a broken hand.

- Illg did not request and review any medical reports from Dr. Taylor or the hospital.

Had he done so, he would certainly have known that Shelby had a fractured metacarpal and not a “broken wrist.” Since Dr. Taylor’s notes were part of the ongoing progress notes of Shelby’s visits to the clinic, Illg might have also seen other useful medical information about Shelby, including the diaper rash she was treated for in September.

- Illg accepted Watkins’ explanation of how Shelby’s injuries *might have* happened, without independently assessing whether it *could have* happened as she claimed.

He did not go to Watkins’ home to verify the existence of a crib and have Watkins demonstrate how Shelby could have fallen from it. He did not find out if knew what happened.

Instead he relied on Dr. Taylor's statement that what Watkins thought might have happened could be a plausible explanation for the injury. Dr. Taylor was not saying he believed her offered explanation, just that it could explain the injury. What Watkins told Dr. Taylor and Illg was still speculation.

According to Iowa law, in situations involving physical injuries, it is child abuse if a child suffers an injury, due to the acts or omissions of a caretaker, that is nonaccidental or at variance with the history given of it. It is the CPW's responsibility to check out the credibility and validity of the explanation given for the cause or mechanism of injury. The DHS Manual provides the CPW is to "assess the credibility" and to describe the "relevant objects [observed]." That means gathering additional evidence, including examining the site of injury and the physical objects involved, and interviewing persons who might have relevant information.

It is the Ombudsman's opinion that Illg should have done further investigation to check out Watkins' explanation and gather relevant evidence to determine whether the explanation was credible and consistent with the evidence. Then, he should have conferred with Dr. Taylor regarding what he determined regarding the explanation, before deciding if the injury was at variance with it.

- Illg remained "quite puzzled about the bruises on Shelby's back," even after Dr. Taylor told him that the lack of a pattern in the bruises suggested it was accidental.

In response to the Ombudsman's question whether an experienced CPW would find the bruises on Shelby's back to be suspicious, Dr. Shah replied in the affirmative.

The Ombudsman believes that if Illg was still "puzzled" about those bruises, he should have conferred with his superiors or the regional child protection specialist and if he still had concerns, consult with a child abuse medical expert.

- Illg made no visit to Watkins' home to gather information for Part B of the Assessment Summary.

The DHS Manual does not require a visit to the family's home on each assessment. It states the following:

In most cases, a visit to the home is essential in conducting an assessment of the child and family....

When you conduct an assessment at an out-of-home setting, (such as a day care center or residential facility), assess the family and environment where the alleged abuse occurred. It may be necessary to include an assessment of the child's own home and family relationships to develop a suggested plan of action.

The Ombudsman believes that even though a home visit may have been completed on a recent assessment, household composition and family members' situations continually change, and it is important to gather the most current information.

Although DHS policy does not require a home visit on each assessment, the Ombudsman concludes Illg should have made a home visit on this assessment, given that Shelby had numerous injuries, most of which allegedly occurred in the home, and given that information about the family and home situation had not been updated recently.

- Illg noted in Part B of the Assessment Summary that he “continue[s] to hear concerns” about Watkins' problem with drugs and alcohol. However, again he did not specify the concerns.

Illg told the Ombudsman the concerns came from two sources during the assessment. Moritz told him that Watkins had a \$500 drug debt. Gosch relayed to him information she received that Watkins used crack or cocaine while working.

Illg was right to have concerns about Watkins involvement with illegal drugs and how that may be affecting the care of her children. Given the founded report in 1996, his continuing distrust of her credibility regarding her involvement with drugs, and the new information from seemingly credible sources, it certainly seemed reasonable for Illg to verify his concerns further.

The Ombudsman believes there were several things Illg could reasonably have done.

One, he could have checked with local law enforcement agencies and the county attorney to find out what information they knew and could share with him to better assess the safety of Watkins' children. Had he done so, he would have learned about the criminal charges filed against Watkins in June 1997 for possession of controlled substances and child endangerment. Dickinson County Deputy Sheriff Rex Ondler, head of the area's drug task force (Iowa Great Lakes Drug Task Force), said he could have given Illg general information about Watkins' alleged drug activity, but he would consult with the county attorney before providing specifics. Law enforcement officers and county attorneys are key players in the child protection system, and unfortunately, they were not alerted to Illg's concerns.

Two, he could have made an unannounced visit to Watkins' home and specifically checked for evidence of illegal drugs or drug paraphernalia. Had he done so, it is possible he might have found some evidence. A friend of Watkins told the Ombudsman that she saw Watkins and Wendelsdorf smoke methamphetamine and marijuana in their bedroom, and saw drugs and drug paraphernalia on the nightstand. Watkins testified at her own trial that she and Wendelsdorf began smoking “Nazi speed” (anhydrous methamphetamine) in September 1999.

Third, he could have requested Watkins undergo random drug tests at this point. However, that was not done until after the next assessment. Even after Watkins agreed to the drug tests on October 22, 1999, DHS workers did not follow up with conducting them.

- Aside from the renewed concerns with drug use, Illg noted hardly any updated information about family functioning or the home environment (for Part B of the Assessment Summary) since the assessment he completed on March 22, 1999.

As in the previous assessment, there is no indication he made any further inquiries about Watkins' boyfriend and his relationship with Watkins and his role with the children. At least he could have found out the boyfriend's name from Watkins. He did not ask [redacted]. Nor did he ask Moritz, who had been a source of information for him on other matters. Moritz testified at Watkins' trial that she knew Wendelsdorf began staying overnight at Watkins' home beginning in August 1999.

Incident # 1999337006 (December 2, 1999 – January 4, 2000)

The report on the Intake form alleged that Shelby had “a cigarette burn on her stomach” and “bruising on her face” and possibly a broken nose. [redacted] told Illg that Shelby's injuries were accidental. She said Shelby had hit her head against a box containing a toy at [redacted] home, and had rubbed her cast across her stomach.

- Illg's description of the bruising on Shelby's face was vague. He did not describe the exact location(s), size, shape, or color(s). He only noted she had “two black eyes that faded very quickly.”

As the Ombudsman discussed earlier in this report, bilateral black eyes may be indicative of abuse, and it is important that the characteristics be recorded accurately.

- Unfortunately, Illg did not take any photographs, which would have provided better documentation of Shelby's injuries. He said that he does not always take photographs because sometimes the camera is not available and sometimes he forgets to take it with him. His office has one camera that is shared by the two CPWs.

DHS policy does not require that photographs be taken of physical injuries. The DHS Manual states that a CPW “may take photographs to show injuries to the child or to document conditions in the household especially in situations that are likely to result in placement on the Central Abuse Registry.”

Armstrong told the Ombudsman the decision to take photographs is left up to the CPW. He said if marks are visible when the CPW observes the child, the CPW should, following best practices, photograph them for documentation. Montoya believed some CPWs are able to describe injuries in more detail, while others may rely more on photographs to document the injuries.

The Ombudsman believes that photographs are valuable to documenting physical injuries and other evidence relevant to an allegation or the explanation given for an injury. Even if injuries are described in detail in an Assessment Summary, photographs can provide useful supporting or corroborating documentation.

The Ombudsman concludes that DHS needs to emphasize and facilitate the taking of photographs to document injuries or other evidence relevant to an allegation of abuse.

- Illg did not interview [redacted], whom [redacted] said had cared for Shelby the afternoon of the day she injured her head.

Clearly, [redacted] should have been interviewed regarding what she saw and what she knew about the cause for the injuries. In addition, since [redacted] she perhaps could have provided information about the family, including whether she has ever observed other injuries on Shelby, whether Watkins was using illegal drugs, who was Watkins' boyfriend and whether he lived with her.

- Although Illg went to [redacted] home, the site of one of the alleged injuries, he did not make a visit to Watkins' home as part of his assessment of the family and the home.

The Ombudsman believes that should have been done, for the reasons stated in the discussion concerning the previous assessment.

- As in the two preceding assessments, Part B of the Assessment Summary was not updated from the one completed on March 22, 1999.
- The Assessment Summary made no reference under "Recommendations" to random drug tests, although in-home services were mentioned.

The Ombudsman believes it is important to note all on-going recommended services in the Assessment Summary for documentation purposes. In addition, it helps to ensure that Supervisors and Case Managers who review the Assessment Summary are following up on all the recommended services.

- The most significant practice problem concerns how Illg responded to the additional information he received about Shelby's condition while this assessment remained open.
 - o First, he received the December 13, 1999 report and subsequent calls from Dawson urging him to take action to protect Shelby. [As discussed under "Intake Process Issues," it is the Ombudsman's opinion that Dawson reported new allegations of abuse.] Even though Illg believed that the facial injuries she was reporting were the same ones he saw on December 3, 1999 and that the alleged sexual abuse was diaper rash, he felt concerned enough to immediately contact Watkins to ask her to take Shelby to a doctor.
 - o Second, Illg learned on December 23, 1999 that, despite his contacts with Watkins, she had not taken Shelby to the doctor.
 - o Third, on December 29, 1999 Case Manager Deb Nelson told him what [redacted], the in-home service provider, had observed on December 23, 1999. Nelson told him that [redacted] thought Shelby's eyes looked awful. Nelson indicated she was having doubts

whether the “black eyes” were from the same injury that they had seen on December 3, 1999. Nelson also told him that she was suspicious of the explanation Watkins’ gave concerning the sores and redness, especially since Watkins did not show the sores and redness to [redacted]. This information frustrated and concerned him enough that he sent a letter to Watkins threatening to request the county attorney to file a juvenile court action if she did not take Shelby to the doctor.

Under DHS policy, the responsibility to continually assess a child’s safety rests with the CPW, not a doctor nor an in-home service provider. It is the Ombudsman’s opinion that it was reasonable, given the additional information he received and the expectations under DHS policy, for Illg to at least go out and see Shelby (observe her again), to ensure that she did not have new injuries that may have been caused by abuse or neglect.

Illg’s responsibility to assess Shelby’s safety did not end when he dictated the Assessment Summary on December 13, 1999. The completion deadline for the Assessment Summary was not until January 3, 2000 (20 business days from receipt of report). There was sufficient time after Dawson’s report for Illg to take additional steps to assure Shelby’s safety. And even though he only had two business days before the completion deadline when he received Nelson’s information on December 29, 1999, he still could have observed Shelby and taken any other assessment action that was appropriate. Depending on the information, he could have submitted an addendum to the pending Assessment Summary or opened a new assessment.

Had Illg gone to see Shelby, the Ombudsman believes it is likely he would have discovered new injuries on her that would have led him to do further assessment. Two friends of Watkins told the Ombudsman they saw different bruises on Shelby’s face continually throughout December, just as Dawson did. Dr. Brad Randall testified at the criminal trials to evidence of bruising on Shelby’s head of varying ages and blows to her abdomen a week or two before her death. Dr. Susan Duffek, who also testified at the criminal trials, found x-ray evidence of four fractured metacarpals that she approximated to have occurred at least two different times in December. She also found evidence of fractured ribs that occurred “two to six weeks” before Shelby’s death.

The Ombudsman concludes there were a number of deficiencies in how the assessments of reports concerning Shelby were conducted. However, the Ombudsman does not speculate the extent to which the deficiencies individually or cumulatively may have impacted Shelby’s life.

Referral for Services

On October 22, 1999 Illg recommended and Watkins agreed to accept in-home services and to submit to random drug testing. The Ombudsman identified two concerns related to the referral for services. First, drug testing was never arranged or conducted. Second, in-home services were not approved until December 15, 1999 and the provider’s first visit to Watkins’ home did not occur until December 23, 1999.

Random Drug Tests

Heckenlively, HSAA, told the Ombudsman that at the time, DHS had drug kits that CPWs and Case Managers could use to collect urine samples and test for certain drugs. Case Managers usually did the drug testing.

[REDACTED]

[REDACTED] Nelson said she also received a copy of the November 18, 1999 Assessment Summary containing the recommendation for random drug tests. The Ombudsman was unable to ascertain what communications occurred between Illg, Slawson, and Nelson about arranging or conducting the drug tests. Nelson told the Ombudsman she never discussed random drug tests with Watkins.

The Ombudsman is concerned that no drug testing took place, especially in light of the evidence revealed at the criminal trials that Watkins was smoking marijuana and methamphetamine. The broader concern is that recommended services may not be followed up or acted upon as quickly as expected due to miscommunications between workers in the referral process.

Length of Time to Implement Services

The Ombudsman noted that it took two months before in-home services were initiated. Services were recommended October 22, 1999.

[REDACTED]

The first step in the paperwork process, however, actually occurs during the assessment. The DHS Manual advises the CPW to complete an “Application for All Social Services” form whenever a report results in an assessment. The Sioux City Region’s policy requires the CPW to “secure a signed Application for Services from the family when the need is identified or the service is requested.” Completion of the form is necessary in order to determine eligibility for services.

Illg told the Ombudsman he did not get Watkins to sign an “Application for All Social Services” on October 22, 1999 because he did not have the form with him then. Nelson did not believe the delay in getting the signed application affected how quickly in-home services were implemented.

While that may have been true in this instance, there may be other situations when adherence to the policy would help to expedite the eligibility determination. The Ombudsman believes CPWs should have a supply of the forms with them when conducting assessments to ensure compliance with the policy.

Delays in initiation of services by DHS can greatly affect the safety and protection of a child and greater efforts must be made to minimize those delays. The Ombudsman believes DHS should review the current procedure -- from the time recommendations are made until the services are initiated -- to determine ways to “streamline” the paperwork process and to expedite the initiation of services.

The Ombudsman concludes that DHS should review the current procedure for referring recommendations to assure that services are acted upon and in a timely manner.

Review of Assessment Summaries

Review by DHS Supervisory Staff

All assessment summaries are subject to review and approval by a supervisor. However, the DHS Manual does not require supervisors to review all the documents (e.g., photographs, medical records, etc.) that may have been gathered by a CPW in the assessment.

Slawson informed the Ombudsman that she tries to review information as it becomes available, but it is not possible for her to review everything in the assessment file in every case. She stated:

I review everything I can.... Because I work in a rural area, it is not always possible to review everything again at the time a report is due.

We are not staffed at the level necessary to review every document, e-mail, letter, photograph, etc., on every case. I believe that workers are trained well and generally do a good job of reviewing with me everything they believe is important or might be controversial.

Illg did not consult with Slawson or Heckenlively regarding the calls he received from Sherry Dawson or Karen Roseberry. In his January 5, 2000 email to Heckenlively he wrote, “Again, this was not something I did intentionally. I just did not talk to them about their opinions.”

Robert Peters, Regional Administrator, Sioux City Region, DHS, told the Ombudsman he was “surprised” that Illg did not have any discussion with Slawson or Heckenlively, considering the number of persons who contacted him in December 1999 and the frustrations they expressed.

Hayward told the Ombudsman his general practice is to select and read 10 percent of the region’s assessment summaries and rejected intakes. The readings he had done did not include any involving the Watkins’ family.

Supervisory review of intakes and assessments is another step within the system to assure that children are adequately protected. However, its effectiveness depends on workers taking the initiative to confer with superiors, and supervisory staff’s ability to be available and to do thorough reviews.

The Ombudsman concludes that supervisory review and consultation regarding intakes and assessments need to be more frequent and complete.

Review by County Attorney

By law, copies of rejected intakes and Part A of the Assessment Summaries are sent to the county attorney. Ed Bjornstad, Dickinson County Attorney, told the Ombudsman that he or another attorney on his staff review the reports that they receive from DHS. He said they read the reports and determine from the recommendations what action is necessary. He added they typically rely on the DHS workers to tell them to proceed with any juvenile court action. He said DHS did not ask or recommend his office to take any action concerning Shelby before her death.

County attorneys play an important role in the protection of a child by taking any legal action which may be necessary or advisable for the child's safety. The Ombudsman believes county attorneys and law enforcement agencies can also serve as resources for information and consultation to DHS workers conducting assessments, and would encourage regular interactions by county attorneys and law enforcement agencies with DHS workers, including active participation on multi-disciplinary teams.

Multi-disciplinary Teams

Iowa law requires DHS to establish multi-disciplinary teams in counties or clusters that receive more than 50 child abuse reports a year. Since teams are composed of professionals with knowledge and skills in different disciplines, they can be a valuable resource to provide advice and feedback to workers conducting assessments. However, teams vary in how frequently they meet, how involved their members are, and how meetings are conducted.

Illg is the coordinator of the Dickinson County Multi-Disciplinary Team. His participation on the team usually involved discussing what he did on assessments.

It's hard for me to explain what they are, but I don't want you to get the impression that they are set up with professionals that you can necessarily bounce things off of. The county attorney, law enforcement, they don't come anymore, because what happens is some of the other providers sit around and they complain about the department or the investigator for not removing all of the kids in the county. They complain to law enforcement about not arresting all of the people that they think should be arrested, and they complain about the county attorney not putting everyone in jail that they feel should go to jail, and that's why those folks won't come anymore, because it turns into a point-the-finger.

According to Illg's appointment calendar, the Dickinson County Multi-Disciplinary Team had a 7:00 a.m. meeting scheduled on October 22, 1999. Illg testified that he could not remember if he attended the meeting - - he recalled neither the discussion nor the attendees. No one takes minutes of meetings, so there is no record of who attended or what was discussed at that meeting. Hayward told the Ombudsman that, if a case was staffed with a team, he would expect to see information about that documented in the Assessment Summary.

The Ombudsman believes Shelby's case was one that would have been appropriate to discuss with the team on October 22, 1999, given the history of DHS involvement with her family and the numerous suspicious injuries that had just been discovered on her the previous day.

If Illg's perception of the Dickinson County Multi-disciplinary Team is correct, then DHS needs to do more to promote and encourage participation on the team, and to provide leadership and guidance on how the team should operate.

The Ombudsman concludes more effort is needed to develop and maintain multi-disciplinary teams that function effectively and can serve as a valuable resource for DHS workers.

Medical Experts and Child Protection Centers

Medical professionals play a significant role in the child protection system, not only as mandatory reporters, but also in providing information and advice to DHS workers.

DHS contracts with several child protection centers throughout the state, to provide medical evaluations and psychosocial assessments. Referrals to these centers usually involve allegations of sexual abuse.

DHS has a contract with the Seasons Center for Community Mental Health (formerly Northwest Iowa Mental Health Center) to operate a child protection center in Spencer. Dr. Kenneth Hunziker, a family physician with Mercy Family Care Clinic in Spencer, does the medical examinations for child protection center. He told the Ombudsman that he did 29 examinations from 1997 to 1999, of which 28 were for alleged sexual abuse, and 1 for alleged sexual and physical abuse. He has received specialized training in examining children and identifying sexual abuse, including use of a colposcope, an instrument used for that purpose. If he is uncertain or wants further consultation on a suspected sexual abuse case, he would refer the case to the larger child protection center in Sioux City.

Dr. Hunziker said that alleged physical abuse cases in the Spencer area are usually referred to family physicians. He indicated he does not have any more training or expertise to identify physical abuse than other family physicians.

DHS noted in its internal review that the lack of adequate medical experts in recent years have affected workers' ability to do their work successfully. The Ombudsman agrees and believes that the current need for medical experts is probably even greater in cases of suspected physical abuse.

The Ombudsman concludes that there is a lack of child abuse medical experts who are readily available to DHS workers as a resource for assistance and advice on child abuse issues.

Recommendations

The following recommendations are not listed in any order of priority. They are presented in sequential order similar to the subject matters discussed in the “Analysis and Conclusions” section of the report.

The Ombudsman recommends:

1. The Department of Human Services (DHS) redesign the child abuse reporting system so that:
 - a. Reporters have a single point of contact which they can be instructed to call, regardless of where they live, the time of day, or the county, cluster or region having responsibility to evaluate the report.
 - b. Reporters are able to speak with an intake worker during their initial call.
 - c. All report information, regardless of who initially receives the report, be promptly documented and retained, timely routed, and appropriately evaluated.

[The Ombudsman believes DHS would gain valuable insight, perspective, and assistance in responding to this recommendation by consulting with appropriate social service staff in states that have a state-wide centralized child abuse hotline system for reports and intakes (such as Arizona, Florida, and Texas), regarding their rationale for and experience in implementation of such a system.]

2. DHS review its definition of who is a “reporter,” and, if possible without statutory change, modify it to also include an individual who has been identified by a reporter (i.e. person calling DHS) as the source of the allegation and as the individual wanting to make a report of child abuse.
3. DHS increase efforts to instruct and remind mandatory reporters about the importance and need to report suspected abuse directly to DHS.
4. DHS increase emphasis on training, encouraging, and reminding mandatory reporters to file written reports and should consider ways to facilitate the filing of written reports.
5. DHS review the 48-hour time frame for filing of written reports by mandatory reporters and determine if it should be enforced and/or extended.
6. DHS modify policy to clearly provide that written reports that are received will be reviewed before a final decision or approval is made to reject the report. In the event a written report is received after a rejection decision is made, a supervisor should review and determine if the rejection decision should be reconsidered.

7. DHS provide public education and awareness to increase reporters and the community's understanding of DHS's role and how the child protection system functions, including the responsibilities and limitations of the various DHS workers.
8. DHS monitor and ensure compliance by employees with the September 18, 2000 policy directive that "information that raises concerns about the care of a child" be relayed to the "child protection unit" and treated as a report of child abuse.
9. DHS adopt a policy providing that intake workers (those responsible for gathering report information and making intake decisions) attempt to speak with every reporter as soon as possible after the reporter has contacted DHS to report child abuse, if that reporter was not able to speak with an intake worker during the initial contact.
10. DHS policy clarify that any report that is rejected, while there is an open assessment about the same child, should be documented as a rejected intake. If it is a duplicate of a report on which there is an open assessment, the duplicate report should also be documented in the Assessment Summary.
11. DHS emphasize, in policy and in the training of intake workers, the need not only to gather, but also to document information relevant to reported allegations of abuse as completely and accurately as possible.
12. DHS provide additional training to intake workers to better ensure appropriate and consistent decisions are made on intake. [The Ombudsman believes creation of a statewide centralized unit to receive reports and complete intakes (see Recommendation #1) will facilitate appropriate, consistent, and adequately documented decision-making.]
13. DHS ensure that any written notice advising a reporter that the report has been rejected state clearly the specific reason for the rejection. If a report is rejected solely because it is a duplicate of a prior report, the reporter should be informed of that reason, unless this would clearly violate confidentiality laws.
14. DHS accord reporters who are notified that their reports are rejected an opportunity to contact an appropriate designated DHS staff person, such as a supervisor or child protection specialist, if they disagree with the decision or have additional questions about the decision.
15. DHS provide additional training to workers involved in child protection about the signs and indicators of physical abuse, sexual abuse, and neglect, the distinguishing characteristics of accidental versus inflicted injuries, and the mechanisms of injuries. DHS also provide additional training for the identification of substance abuse, particularly the use of methamphetamine and how that impacts family dynamics and child safety.
16. DHS modify policy to require that, in the event DHS refers a child for examination by a physician, the child protection worker (CPW) attempt to contact the physician in advance of the examination and inform the physician about the child's injury or condition, any explanation given for the injury or condition, and other pertinent history concerning the

child. If the CPW discovers during the assessment any additional relevant information regarding the cause or explanation for the child's injury or condition, the CPW should contact and confer with the doctor again.

17. DHS adopt a policy encouraging the use of cameras, bruising color charts, and injury measurement instruments in conducting assessments, whenever possible, to document visible injuries and other evidence relevant to the assessment. All CPWs should be equipped with a camera, a bruising color chart, and injury measurement tools. DHS should also develop and provide an appropriate training curriculum for the use of cameras, color charts and injury measurement tools.
18. DHS clarify policy stating when it is essential or necessary to make a visit to the home in conducting an assessment of the child and the family, and when it may be appropriate to attempt unannounced home visits.
19. DHS and the Iowa General Assembly review the 20 business day time frame for completion of assessments to determine if it allows adequate time to conduct thorough assessments and complete the written Assessment Summaries. Consideration should be given to allow supervisors and program staff to grant limited extensions in cases when extensions are clearly necessary.

[Although the Ombudsman did not find any evidence to indicate that the 20 business day time frame for completion of an assessment impacted how Shelby Duis' case was handled, the Ombudsman believes that a rigid 20 day time frame may be an artificial and potentially counterproductive requirement.]

20. DHS develop a standardized process for recommending and making referrals for DHS services, to assure that recommended services are properly and timely referred and acted upon. DHS develop a separate referral form or revise a current referral form to prominently document the specific services recommended, any priority or urgency in implementing them, and any subsequent actions taken on the recommendations (i.e., approval, assignment, referral, initiation).

DHS should review the process for recommending, referring and initiating services, including completion of necessary paperwork, to find ways to improve the initiation and delivery of services.

21. DHS 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 adopt a policy requiring supervisors to review all relevant information in the assessment file, before approving the Assessment Summary; DHS evaluate whether it has necessary staffing resources especially in rural clusters; 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.

22. DHS review how effectively multi-disciplinary teams are functioning across the state and find ways to improve the development and utilization of all multi-disciplinary teams as a resource for CPWs.
23. DHS and other appropriate Iowa officials, such as the Attorney General, the Department of Public Health, and the University of Iowa Hospitals and Clinics collaboratively study the accessibility to and the sufficiency of medical child abuse expertise available to DHS child protection staff. Based upon this evaluation, take the necessary steps to provide or obtain such expertise.

Appendix

STATE OF IOWA

CITIZENS' AIDE/OMBUDSMAN
CAPITOL COMPLEX
215 EAST 7TH STREET
DES MOINES, IOWA 50319-0231
(515) 281-3592
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WILLIAM P. ANGRICK II
CITIZENS' AIDE / OMBUDSMAN

February 10, 2000

Jessie Rasmussen, Director
Iowa Department of Human Services
Hoover Building
LOCAL MAIL

Dear Ms. Rasmussen:

As you are aware, the office of the Citizens' Aide/Ombudsman has been asked to investigate the Department of Human Services' (DHS) policies and practices in the handling of child abuse allegations regarding Shelby Duis.

Pursuant to Iowa Code Chapter 2C, notice is hereby given that the office of the Citizens' Aide/Ombudsman is initiating a formal investigation in this matter. This investigation shall include, but not be limited to, a review of the actions taken and decisions made by the DHS staff as a result of reported allegations of child abuse.

As part of my investigation, I am requesting documents and records related to this case. Enclosed is a subpoena for that information.

I have assigned Ruth Cooperrider, Deputy/Legal Counsel, Wendy Sheetz, Assistant and Don Grove, Assistant to this investigation.

If you have any questions regarding this matter, please contact me.

Sincerely,

William P. Angrick II

WPA:WLS:ml

Enclosure
000565a.wls

In the matter of Iowa Citizens' Aide/Ombudsman Complaint Investigation:)
)
)
)

Return of Service of Subpoena Duces Tecum

This is to certify that I have served this subpoena duces tecum on Director Rasmussen by delivering a copy of it to him/her on the 10th day of February, 2000.

Wendy L. Pratt
Signature

SUBSCRIBED AND SWORN before me this 10 day of February, 2000.

Assistant
Title

Rene White - exp. May 3, 2000

NOTARY PUBLIC for the State of Iowa

Phone: 515-281-3592
Toll Free: 1-888-IA-OMBUD
FAX: 515-242-6007
Internet: OMBUD@Legis.State.IA.US



Iowa Citizens' Aide/Ombudsman Office
Capital Complex
215 East Seventh Street
Des Moines, Iowa 50319-0231

Iowa Department of Human Services

REPORT OF SUSPECTED CHILD ABUSE

(See back for instructions.)

This form may be used as the written report which the law requires all mandated reporters to file with the Department of Human Services, following an oral report of suspected child abuse. Fill in as much information under each category as is known. Submit the completed form to the county office of the Department of Human Services within 48 hours of oral report.

FAMILY INFORMATION

Name of Child: _____ Age: _____ Date of Birth: _____

Address: _____

Phone: _____ School: _____ Grade Level: _____

Name of Parent or Guardian: _____ Phone (if different from child's): _____

Address (if different from child's): _____

Other Children in the Home:

NAME	BIRTHDATE	CONDITION

INFORMATION ABOUT SUSPECTED ABUSE: In this section, indicate the date of suspected abuse; the nature, extent and cause of the suspected abuse; the person(s) thought to be responsible for the suspected abuse; evidence of previous abuse; and other pertinent information needed to conduct the investigation. Use the back of this form if necessary to complete the information requested above and to identify individuals who have been informed of the child abuse report, such as building administrator, supervisor, etc.

REPORTER INFORMATION

Name and Title or Position: _____

Office Address: _____

Phone: _____ Relationship to Child: _____

Name(s) of other mandatory reporter(s) who has/have knowledge of the abuse: _____

Signature of Reporter	Date
-----------------------	------

COUNTY _____

DON'T EVER GIVE OUT A CASE WORKER'S NAME OR PHONE NUMBER TO ANY CALLER

CHILD – DEPENDENT ADULT PROTECTIVE INVESTIGATIONS CONTACT REPORT

DAY _____ DATE _____ HOTLINE WORKER _____

TIME START _____ TIME END _____

CALLER'S NAME _____ CALLER'S PHONE _____

ADDRESS _____ ANONYMITY YES NO

CITY _____ STATE _____ ZIP CODE _____

NAME OF CHILD/ADULT _____ AGE _____ DOB _____

1 _____

2 _____

3 _____

4 _____

5 _____

WHERE IS VICTIM RIGHT NOW _____

WHERE DID ABUSE TAKE PLACE _____

_____ PHYSICAL _____ SEXUAL _____ DENIAL OF CRITICAL CARE (NEGLECT)

SUSPECTED ABUSER _____

ADDRESS _____ CITY _____ STATE _____

PHONE _____ RELATION TO VICTIM _____

PARENT/GUARDIAN _____

ADDRESS _____ CITY _____ STATE _____

PHONE _____ RELATION TO VICTIM _____

DESCRIPTION OF ABUSE _____

SOCIAL WORKER _____ TIME CALLED _____

PHONE NUMBER _____ CALL RETURNED _____

IF NOT RESPONDED TO IN 15 MINUTES..... PAGE WORKER AGAIN

Appendix C

How to take a Hotline Call

1. The phone rings..Answer by saying "Central Abuse Hotline, How can I help you?"
2. Write down the date and the time the that call comes in.
3. Try to get the callers name and phone number. If the caller does not want to give out that information its okay.
4. Get the County that the child/dependent adult lives in. That determines what County you will be paging.
5. Ask the caller the names of the people getting abused. Try to get either their date of birth or their age
6. Ask the caller for the address of the people getting abused. If they do not know the address, they may be able to give brief directions. (The abuse worker may be familiar with the area)
7. Ask the caller the name of the abuser, their relationship to the person getting abused, and their address/phone number. The caller may not have all of that information, just get what you can.
8. Get the parents names, address and phone number of the people getting abused
9. Get a brief description of the abuse taking place. Key things the worker will ask for are dates the abuse took place, are there any marks, if so where and how long the abuse has been happening.
10. If you get all the above information and the caller is still willing to talk, ask the rest of the questions on the contact report.
11. The most important information to get is the county and the address of the person getting abused.

How to Page an Abuse Worker

1. In the blue book, find the county name that the person being abused lives in.
2. Before you write down anything, review the page. Make sure it's the correct month, etc.
3. After reviewing the page, find the correct date. The name of the on call worker should follow or be near the date.
4. On the Contact Report write the name of the on call worker
5. Most counties have pager numbers. Follow the directions that are on the page. If there aren't directions there should be prompts on the phone after you dial the toll free number
6. If the county does not use pagers, follow the directions on the page.
7. After paging/calling for a worker, write the time you called them on the contact report.
8. If you have not received a call back in fifteen minutes, call/page them again.
9. If you still have not a call back in 30 minutes page them again.
10. You are the best judge of how urgent the call is. If the call seems to be urgent, don't wait 30 minutes to page the worker again.
11. If you feel the call is urgent, refer to the on call roster and page/call the on call supervisor. If you do not get a response from them, keep calling names on the list until you get a response.
12. If the call seems a serious emergency and you cannot get a worker or supervisor to return the call, call the sheriff in the county where the child/dependant adult are and explain to them the situation. They will take it from there.

CHILD PROTECTIVE SERVICES INTAKE

Service Intake
 Child Abuse Intake
 Date: _____
 Time: _____
 County #: _____

Intake Person: _____
 Assigned Worker: _____
 Incident #: _____

Household Name and Address: _____

Directions to Home: _____

Telephones: (Household) _____ (Other) _____

Current Location of Child Subject: _____

ALLEGATIONS:

ABUSE TYPE:
 Physical Injury
 Mental Injury
 Sexual Abuse
 Child Prostitution
 Denial of Critical Care
 Presence of Illegal Drugs
 None, Service Referral Only

HOUSEHOLD COMPOSITION

Name	Birth Date	Role	Sex	Race	SS Number	FACS Number	Comments

NONCUSTODIAL PARENT OR COLLATERAL SOURCES:

Name: _____
 Phone: _____
 Relationship: _____

Address: _____

Comments: _____

Name: _____
 Phone: _____
 Relationship: _____

Address: _____

Comments: _____

Appendix D

PERSON REPORTED AS RESPONSIBLE FOR ALLEGED ABUSE:

Name:	DOB:	SS#:	FACS#:
Address:		Phone (H):	
Comments:		Work Phone (W):	
Name:	DOB:	SS#:	FACS#:
Address:		Phone (H):	
Comments:		Work Phone (W):	

WORKER SAFETY CONCERNS:**DISPOSITION:**

<input type="checkbox"/> Service Referral Accepted and Assigned to:	Date:	Time:
<input type="checkbox"/> Child Abuse Report Accepted and Assigned to:	Date:	Time:
<input type="checkbox"/> Child Abuse Report Rejected by:	Date:	Time:

Reasons for Rejection: Reporter Notified of Rejection**REPORTER or REFERRAL SOURCE:**

NAME (Including Title and Agency):	
ADDRESS:	
PHONE:	REPORTER TYPE: <input type="checkbox"/> Mandatory <input type="checkbox"/> Permissive
<input type="checkbox"/> ACAN <input type="checkbox"/> FACS	State ID
<input type="checkbox"/> IABC <input type="checkbox"/> STAR	

Additional Information:

Iowa Department of Human Services

CHILD PROTECTIVE ASSESSMENT SUMMARY PART A

REPORT INFORMATION: Completion Date: Addendum Date:

Intake Date: Child Protection Worker: Incident: County:
 Household Address:
 Directions to Home:
 Telephones: (Household) (Other)
 Current Location of Child/Subject:

TYPE OF ASSESSMENT SUMMARY:
 Non-Registered Registered Addendum to a previously completed written summary

HOUSEHOLD COMPOSITION:
 SEX: M=Male, F=Female; RACE: A=African-American, B=Biracial, C=Caucasian, H=Hispanic, N=Native American, P=Pacific Islander or Asian, I=Indochinese, O=Other, U=Unknown; ROLE: V=Child Subject, S=Sibling, P=Parent, F=Foster Parent, R=Relative, L=Paramour, O=Other.

NAME	DOB	ROLE	SEX	RACE	SS#	FACS #	COMMENTS

NONCUSTODIAL PARENT:

NAME: PHONE:
 ADDRESS:
 PARENTS OF:
 COMMENTS:

PERSON DETERMINED RESPONSIBLE FOR ABUSE: (Only if abuse is confirmed.)

NAME: DOB: SS#: FACS#: RELATIONSHIP:
 ADDRESS: PHONE:
 COMMENTS: WORK PHONE:

ABUSE REPORTED: (Include additional concerns that arise during the course of the assessment.)

ASSESSMENT OF CHILD SAFETY:

SUMMARY OF CONTACTS:

DETERMINATION AS TO WHETHER ABUSE DID OR DID NOT OCCUR: (If registry placement is made, list all factors necessary for this decision, using the Child Protective Handbook.)

RATIONALE FOR PLACEMENT OR NON-PLACEMENT ON REGISTRY:

JUVENILE COURT INVOLVEMENT REQUESTED, INCLUDE DATE AND TYPE OF ACTION REQUESTED, IF ANY: (If action is requested, state date and specific action requested.)

CRIMINAL COURT INVOLVEMENT REQUESTED, INCLUDE DATE AND WHO REFERRED TO IF ANY REQUESTED: (If action is requested, state date, time, and type of action requested.)

Attachments (if any, list):

_____, Child Protection Worker Date
 _____, Supervisor Date

(Rev 7/97)

Iowa Department of Human Services
CHILD PROTECTIVE ASSESSMENT SUMMARY - Part B
Assessment of the Child and Family Functioning, and Development of Suggested Plan of Action

COMPLETE DATE:		ADDENDUM DATE:	
INTAKE DATE:	CHILD PROTECTION WORKER:	INCIDENT:	COUNTY:
HOUSEHOLD ADDRESS:			
DIRECTIONS TO HOME:			
TELEPHONES: (Household)		(Other)	
CURRENT LOCATION OF CHILD/SUBJECT:			

TYPE OF ASSESSMENT SUMMARY: Addendum to a previously completed written summary

HOUSEHOLD COMPOSITION: SEX (M) Male, (F) Female; RACE (A) African-American, (B) Bi-Racial, (C) Caucasian, (H) Hispanic, (N) Native American, (P) Pacific Islander/Asian, (I) Indo-Chinese, (O) Other, (U) Unknown; ROLE (V) Child Subject, (S) Sibling, (P) Parent, (F) Foster Parent, (R) Relative, (L) Paramour, (O) Other.

NAME	DOB	ROLE	SEX	RACE	SS#	FACS#	COMMENTS

HISTORY OF SERVICES

PRESENTING PROBLEM

EVALUATION OF THE FAMILY FUNCTIONING - STRENGTHS AND NEEDS: (Describe each of the following, identifying strengths and needs.)

- Home Environment:**

- Parent/Caretaker:**

- Child(ren):** (Include all children in home.)

- Domestic Violence/Substance Abuse:**

- Social/Environment:**

Analysis of Family Functioning (Strengths and Needs) in Relation to Child(ren)'s Safety: (Provide rationale)

SUGGESTED PLAN OF ACTION: (Provide rationale for any of the following suggested plans of action recommended, indicate with a N/A if the section is not applicable.)

- Identification/Development of Informal Supports for Child and/or Family (if any):**

- Identification/Development of Services Provided by Community Agencies or Organizations (if any):**

- Department Services Provided and Recommendations (if any):**

, Child Protection Worker	Date
, Supervisor	Date

Iowa Department of Human Services

CHILD PROTECTIVE ASSESSMENT SUMMARY PART A

REPORT INFORMATION:

Completion Date: 03/22/1999

Addendum Date:

Intake Date: 02/22/1999 Child Protection Worker: CHUCK ILLG

Incident: [REDACTED]

County: DICKINSON

Household Address: 1501 JACKSON ST, SPIRIT LAKE, IA 51360

Directions to Home:

Telephones: (Household) [REDACTED] (Other)

Current Location of Child/Subject:

TYPE OF ASSESSMENT SUMMARY:

Non-Registered Registered Addendum to a previously completed written summary

HOUSEHOLD COMPOSITION:

SEX: M=Male, F=Female; RACE: A=African-American, B=Biracial, C=Caucasian, H=Hispanic, N=Native American, P=Pacific Islander or Asian, I=Indochinese, O=Other, U=Unknown; ROLE: V=Child Subject, S=Sibling, P=Parent, F=Foster Parent, R=Relative, L=Paramour, O=Other.

NAME	DOB	ROLE	SEX	RACE	SS#	FACS #	COMMENTS
MCKNIGHT, HIEDE	[REDACTED]	P	F	C	[REDACTED]	[REDACTED]	
DUIS, SHELBY	[REDACTED]	V	F	C	[REDACTED]	[REDACTED]	
MCKNIGHT, TYLER	[REDACTED]	S	M	C	[REDACTED]	[REDACTED]	

NONCUSTODIAL PARENT:

NAME: UNKNOWN, FATHER PHONE:
ADDRESS: UNKNOWN, UNKNOWN, IA 51360
PARENTS OF:
COMMENTS:

PERSON DETERMINED RESPONSIBLE FOR ABUSE: (Only if abuse is confirmed.)

NAME: DOB: SS#: FACS#: RELATIONSHIP:
ADDRESS: PHONE:
COMMENTS: WORK PHONE:

ABUSE REPORTED: (Include additional concerns that arise during the course of the assessment.)

Reporter states that Shelby has a black eye which looks like it was inflicted.

[REDACTED]

[REDACTED]

[REDACTED]

COLLATERALS

[REDACTED] - Small World Day Care - Spirit Lake, IA 51360

ASSESSMENT OF CHILD SAFETY:

470-3240 (12/95)

Appendix F

After meeting with Heide McKnight; her daughter, Shelby Duis; and her son, Tyler McKnight, this worker has little concern regarding the children's physical well-being. [REDACTED]

[REDACTED] In speaking with Heide, this worker believes that the injury to Shelby was accidental.

SUMMARY OF CONTACTS:

Heide McKnight lives with her two biological children; Shelby Duis and Tyler McKnight.

BODY OF REPORT

On 2-22-99 at 9:15 A.M., this worker received the intake information. The reporter stated that Shelby has a black eye and that there is a concern that the black eye was inflicted. The reporter stated that Shelby Duis is currently attending the Small World Day Care Center.

At 9:30 A.M., this worker called the Small World Day Care Center. This worker then spoke with [REDACTED]. This worker introduced himself to [REDACTED] and explained the allegations that I had received. This worker asked [REDACTED] if it would be possible to come to the Small World Day Care Center to view Shelby Duis. [REDACTED]

[REDACTED] Due to the fact that this child had a current injury, this worker felt it was necessary to see her as soon as possible.

At 12:40 P.M., this worker arrived at the Small World Day Care Center and met with Shelby Duis. This worker would like to note that Shelby was sleeping at the time this worker arrived at the day care center. This worker explained to [REDACTED] that it was not necessary to wake up Shelby. This worker did take photographs of Shelby's face. Those photographs are contained in the case file. This worker would like to note that there is a bruise primarily located on the left cheek of Shelby. There is a bruise, approximately the size of a nickel, which is very faint. This worker would like to note that there is also some discoloration underneath Shelby's left eye. This worker then asked [REDACTED] to please explain when they first noticed the injury. [REDACTED] stated that the black eye was not there on Friday. This worker then asked [REDACTED] if any explanation was given as to why she had a bruise on her cheek and discoloration underneath her eye. [REDACTED] stated that [REDACTED], stated to them that Heide's bedroom has a bedroom door which was left open and Shelby ran into it. This worker then asked if [REDACTED] stated when that occurred. [REDACTED] stated that [REDACTED] did not give any date as to when that happened. Staff also stated that Shelby does not talk so they can not ask her what happened. Staff stated that there have been bruises on Shelby's forehead and her hairline before but nothing that looked out of the ordinary for a child that age. However, [REDACTED] did state that Shelby is not accident prone. [REDACTED] stated that Shelby walks very good and is very steady on her feet. [REDACTED] stated that she was concerned because there appears to an increase in bruises the past two weeks. [REDACTED] stated that Heide has a new boyfriend and she is concerned that maybe the new boyfriend is not treating Shelby the way he should. [REDACTED] stated that Shelby has hit and punched the other children at the day care center.

At 1:10 P.M., this worker contacted [REDACTED] to find out when Heide would be returning from work. This worker would like to note that Heide works for her step-father's construction company. [REDACTED] stated to this worker that Heide was working in Spencer and she did not know when she would be returning. [REDACTED] then stated to this worker that if I was calling about the bruise on Shelby's face, she could explain that. This worker

explained to [REDACTED] that I was unable to speak with her about any details, but I was willing to listen. [REDACTED] stated that Shelby simply ran into the bedroom door. [REDACTED] stated that Shelby is not being beat by her mother. [REDACTED] stated that she was very angry that this would be turned into the Department of Human Services. [REDACTED] stated that Heide's bedroom door goes into the dining room. [REDACTED] stated that the dining room then runs into the kitchen room, which runs into the living room. [REDACTED] stated that when all the door are open, the children can run around the house in a circle from room to room. [REDACTED] stated that, usually, Heide's bedroom door is closed but, on Saturday, it was left open. [REDACTED] stated that on Saturday Tyler and Shelby were running around the house in a circle from room to room. [REDACTED] stated that she knows that it what happened because, right after it happened, Heide went to the shop to get some plywood from her step-father to put up between the dining room and the bedroom. [REDACTED] stated that the children are able to open one of the doors to Heide's bedroom so she put up the plywood so they could no longer open the door plus it would give her some privacy. [REDACTED] stated that the bruise to Shelby's face happened Saturday morning. [REDACTED] stated that Saturday night when she saw Shelby, the bruise was there. [REDACTED] stated that Heide told her that the bruise really didn't show up until later that evening. [REDACTED] stated that Heide even joked that she would probably get turned into the Department of Human Services because of this. [REDACTED] stated that she was unsure what the injury looked like today but yesterday the eye was turning blue and it looked bad.

At 2:21 P.M., this worker received a phone call from Heide McKnight. This worker explained the allegations to Heide. Heide stated that Tyler was at his father's house and was not even in the home when this happened to Shelby.

[REDACTED]. Heide stated that [REDACTED] was mistaken; [REDACTED]. Heide stated that she was watching one of her friend's children but that [REDACTED]. Heide explained to this worker that the injury to Shelby's face was an accident and, in no way, was it inflicted. Heide and this worker then agreed to meet on 2-23-99 at 6:15 P.M.

On 2-23-99 at 6:20 P.M., this worker met face to face with Heide McKnight, Tyler McKnight, and Shelby Duis. This worker then again explained the allegations to Heide. Heide stated that, on weekends, her house turns into the neighborhood hang out. Heide stated that last Saturday there were children over playing and they were chasing each other around the house. Heide stated that Shelby is at the age that when someone chases her, she thinks it's really funny. Heide stated the problem with that is that she starts running but always turns around and looks back to see if the person is still chasing her. Heide stated that Shelby ran into the door frame on her own bedroom and that is how she got the bruise. Heide stated that she did not see it happen but she heard Shelby crying right away and [REDACTED] and [REDACTED] said that is what happened. This worker would like to note that Heide does not know the last names of [REDACTED] and [REDACTED]. Heide stated that there was no bruise Saturday morning when it happened but, later Saturday night, it started to bruise on her cheek. Heide stated that when she woke up Sunday, she had a little bruise underneath her eye and, as the day went on, it started to get darker. Heide then took this worker into the doorway between Shelby's bedroom and her bedroom. Heide stated that she got a piece of plywood from her step-father's construction company to put up so the children can not run in circles. Heide then showed this worker the door frame which Shelby ran into. This worker would like to note that the door frame in the house is not a smooth surface. Heide lives in an older, but very nice home. The woodwork on the door frame is notched and grooved. This worker then talked with Heide about the concern that the injury could have been inflicted. Heide adamantly denied that she did anything to cause the bruise on Shelby's face. This worker would like to note that after seeing the door frame and the fact that the bruise is isolated on the cheek bone, this worker agrees with Heide that it probably was not inflicted by a slap mark. If the injury was caused by Shelby being slapped, this worker would expect to see additional bruising on the left side of Shelby's face. This worker then asked Heide about whether or not her boyfriend could have caused the injury. Heide stated no. Heide stated that she does have a friend that she is dating but he has never been alone with Shelby or Tyler. Heide stated that her boyfriend does not live with her and that the only time he would see the children if he came over to visit her or they all went over to his house to visit him.

DETERMINATION AS TO WHETHER ABUSE DID OR DID NOT OCCUR: (If registry placement is made, list all factors necessary for this decision, using the Child Protective Handbook.)

This report of Physical Abuse is UNCONFIRMED. In unconfirming this report, this worker has found some of the following factors not to have been met.

FACTOR 1. Shelby Duis is a child, [REDACTED].

FACTOR 2. Heide McKnight is an adult, [REDACTED].

FACTOR 3. A physical injury to the child has occurred. Shelby does have a bruise approximately the size of a nickel which is very faint on her left cheekbone. This worker would also like to note that there is some discoloration under Shelby's left eye.

FACTOR 4. The injury appears to be accidental. After meeting with Heide and having Heide show me exactly what happened to cause the injury, this worker feels comfortable in saying that the injury was an accident and it was caused by Shelby running into the door frame on her own bedroom door. This worker would also like to note that when I spoke with [REDACTED] also stated that the injury was caused by Shelby running into the door frame on her door.

FACTOR 5. The injury did not result from the acts or omissions of Heide McKnight.

RATIONALE FOR PLACEMENT OR NON-PLACEMENT ON REGISTRY:

This report of Physical Abuse is UNCONFIRMED and is; therefore, not placed on the Child Abuse Registry.

JUVENILE COURT INVOLVEMENT REQUESTED, INCLUDE DATE AND TYPE OF ACTION REQUESTED, IF ANY:
(If action is requested, state date and specific action requested.)

This is an UNCONFIRMED report regarding Heide McKnight and Shelby Duis. This worker is not recommending any Juvenile Court intervention at this time. [REDACTED]

CRIMINAL COURT INVOLVEMENT REQUESTED, INCLUDE DATE AND WHO REFERRED TO IF ANY REQUESTED: (If action is requested, state date, time, and type of action requested.)

This worker is not making any recommendations for law enforcement to follow-up on this allegation.

(Rev 7/97)

Attachments (if any, list):

CHUCK ILLG, Child Protection Worker	03/22/1999
Phyllis Slawson	Date
PHYLLIS SLAWSON, Supervisor	03/22/1999
	Date

(Rev 7/97)

Iowa Department of Human Services
CHILD PROTECTIVE ASSESSMENT SUMMARY - Part B
Assessment of the Child and Family Functioning, and Development of Suggested Plan of Action

COMPLETE DATE: 03/22/1999		ADDENDUM DATE:	
INTAKE DATE: 02/22/1999	CHILD PROTECTION WORKER: CHUCK ILLG	INCIDENT: [REDACTED]	COUNTY: DICKINSON
HOUSEHOLD ADDRESS: 1501 JACKSON ST, SPIRIT LAKE, IA 51360			
DIRECTIONS TO HOME:			
TELEPHONES: (Household) [REDACTED]		(Other)	
CURRENT LOCATION OF CHILD/SUBJECT:			

TYPE OF ASSESSMENT SUMMARY: Addendum to a previously completed written summary
 HOUSEHOLD COMPOSITION: SEX (M) Male, (F) Female; RACE (A) African-American, (B) Bi-Racial, (C) Caucasian, (H) Hispanic, (N) Native American, (P) Pacific Islander/Asian, (I) Indo-Chinese, (O) Other, (U) Unknown; ROLE (V) Child Subject, (S) Sibling, (P) Parent, (F) Foster Parent, (R) Relative, (L) Paramour, (O) Other.

NAME	DOB	ROLE	SEX	RACE	SS#	FACS#	COMMENTS
MCKNIGHT, HIEDE	[REDACTED]	P	F	C	[REDACTED]	[REDACTED]	
DUIS, SHELBY	[REDACTED]	V	F	C	[REDACTED]	[REDACTED]	
MCKNIGHT, TYLER	[REDACTED]	S	M	C	[REDACTED]	[REDACTED]	

HISTORY OF SERVICES

Heide stated that the only type of therapy or counseling that the family has had is that when she and her first husband divorced, [REDACTED]. Heide stated that she thinks it was offered through the Spirit Lake Elementary School. Heide denies that she has ever been involved with any alcohol or drug treatment classes.

PRESENTING PROBLEM

Heide stated that, lately, she has really been doing very well. Heide stated that she and the children are getting along good and, as a family, they really do not have any problems. Heide stated that she works for her step-father and is making a good wage. Heide stated that the children usually listen to her though there are those times when [REDACTED]. Heide stated that her divorce was hard, at first, and it was hard on the whole family. Heide stated that, right after the divorce, she and her ex-husband did not get along but they are getting along better now. Heide stated that her ex-husband has a new girlfriend who is really nice and really good to the children. Heide stated that it sounds weird but since her ex-husband has started dating his new girlfriend, they are actually able to get along better. Heide stated that she has even gone out with his new girlfriend. Heide stated that she gets [REDACTED]. Heide stated that she has no contact with Shelby's father and does not receive child support. Heide stated that Child Support Recovery is not able to locate Shelby's father. Heide stated that the family does not receive any assistance from the State Of Iowa.

ASSESSMENT OF THE CHILD AND FAMILY FUNCTIONING: (Describe each of the following, identifying strengths and needs.)

Home Environment:

Heide stated that they moved into the house they are living at now the end of November. Heide stated that she is renting the home from her parents. This worker would like to note that it is an older house but it is very nicely decorated and very nicely kept. The home environment, in no way, poses any danger to Heide's children.

Parent/Caretaker:

Heide stated that she grew up in Spirit Lake, IA. Heide stated that she has five older brothers. Heide stated that her mother and father divorced when she was ten years old. Heide stated that she lived with her mother after the divorce. Heide stated that she and her mother have always been very close and have always gotten along really well together. Heide stated that she dropped out of high school in the eleventh grade. Heide stated that school was really hard for her and that is why she dropped out. Heide stated that if she would have stayed in school, she would have had to retake her freshman year of classes. Heide stated that she moved out of her mother's home two months before she turned eighteen years old. Heide stated that her brother was killed in a helicopter accident in Japan that summer and things were really hard that summer for both her and her mother. Heide stated that when all of that was going on, she decided to move out of the home. Heide stated that she married Troy McKnight in 1990. Heide stated that the two of them lived together a year before they were married. Heide stated that the divorce was finalized in 1998 though the two of them separated in 1994. Heide stated that she and Troy's marriage did not work [REDACTED]

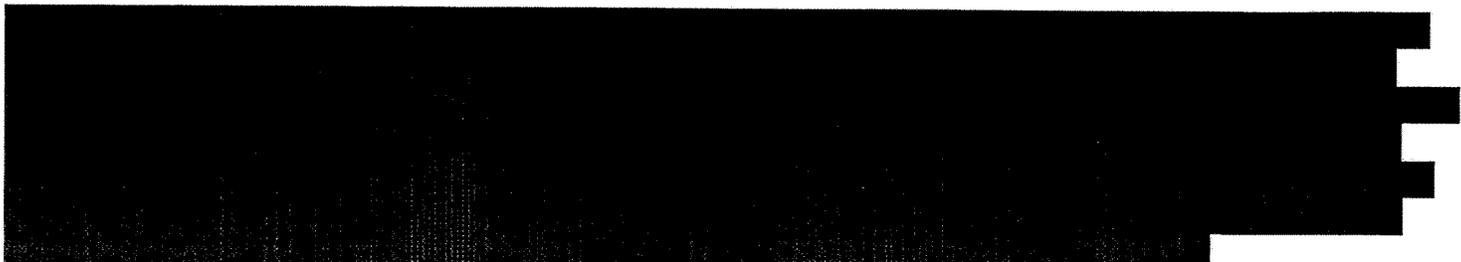
[REDACTED] Heide stated that she and Kevin Duis, Shelby's father, started to live together in 1995. Heide stated that that relationship ended in early 1997 before Shelby was even born. Heide stated that that relationship did not work because Kevin was a creep. Heide stated that Kevin has only seen Shelby twice and that is when she was a very young baby. Heide states that she works for Moritz' Construction and she has worked there for the past five years. Heide stated she has a good boss because her step-father owns the company. Heide stated that she enjoys riding bikes with her children and she enjoys going water skiing. Heide also stated that she has a friend that has a boat so she and the children enjoy boating in the summer together. Heide also states that she likes to take the children to the park so that they can play. Heide stated that her best qualities are that she is a hard worker and a good mother. Heide stated that she is really easy to get along with. When this worker asked Heide what she would change about herself, Heide stated that she may be a little too lenient when it comes to discipline. Heide stated that her job is very demanding and physically tiring. Heide stated that sometimes she is just too tired to deal with the children's behaviors. This worker then talked with Heide about drug use. This worker would like to note that, in the past, this worker has always had a concern about Heide abusing drugs. Heide denied that there was any drug use currently.

Domestic Violence:

Heide stated that there has never been any domestic violence in any of her relationships.

Child(ren): (Include all children in home.)

Heide stated that Shelby goes to Small World Day Care. Heide stated that she thinks that Small World does a really good job with Shelby. Heide stated that Shelby has gone there since right after she was born. Heide stated that Shelby is very active and is a smiley child. Heide stated that Shelby is always on the go and is always running through the house. Heide stated that Shelby will climb on anything she finds. Heide stated that Shelby is in good health and has never had any serious medical problems.



Social/Environment:

Heide stated that the family does not belong to any groups, organizations, or church. [REDACTED]. Heide stated that she can always count on her mother and step-father to help her out if things get tough. Heide again stated that she and her mother have always been very close and have always had a very good relationship. Heide also stated that she is close to her biological father who lives in Spirit Lake, IA. Heide stated that one of her closet friends is [REDACTED] and that she can always count on [REDACTED] to help her out. Heide stated that [REDACTED]. Heide stated that she has to go to work early in the morning so her mother comes over and gets Tyler and Shelby up and ready for the day. Heide stated that her mother then takes Tyler to school and then takes Shelby to Small World Day Care.

SUGGESTED PLAN OF ACTION: (Provide rationale for any of the following suggested plans of action recommended, indicate with a N/A if the section is not applicable.)

Identification/Development of Informal Supports for Child and/or Family (if any):

Heide stated to this worker that she has lived in the Spirit Lake area all her life and has worked for her step-father for the past five years. Heide stated that the family is very active and are always on the go. Heide states that she is very close to her biological father, her biological mother, and her step-father. Heide stated that she has friends that will help her out when she is in need. This worker would like to note that, at this point in time, this worker has no specific recommendations for any additional informal supports to be developed.

Identification/Development of Services Provided by Community Agencies or Organizations (if any):

Again, Heide stated that she has lived in Spirit Lake, IA, all her life. Heide stated that she is active in the community though she doesn't belong to any specific groups, organizations, or church. Heide has taken advantage of community agencies/organizations to help benefit she and her children. Heide stated that her mother comes over every morning and helps gets Tyler and Shelby up and gets them off to school and to Small World Day Care. Heide stated, in the summer time, [REDACTED]. It appears that this family is utilizing community agencies and supports for the betterment of their family.

Department Services Provided and Recommendations (if any):

After assessing the informal supports and the community supports, this worker is not making any recommendations for services to be provided by the Department of Human Services. Heide appears to have a good informal support system in place and is taking advantage of the community supports that are available to her and the children.

CHUCK ILLG, Child Protection Worker
Phyllis Slawson

PHYLLIS SLAWSON, Supervisor

03/22/1999

Date
03/22/1999

Date

(Rev 7/97)

Iowa Department of Human Services

CHILD PROTECTIVE ASSESSMENT SUMMARY PART A

REPORT INFORMATION:

Completion Date: 11/18/1999

Addendum Date:

Intake Date: 10/21/1999 Child Protection Worker: CHUCK ILLG

Incident: [REDACTED]

County: DICKINSON

Household Address: 1501 JACKSON ST., SPIRIT LAKE, IA 51360

Directions to Home:

Telephones: (Household) (Other)

Current Location of Child/Subject:

TYPE OF ASSESSMENT SUMMARY:

Non-Registered Registered Addendum to a previously completed written summary

HOUSEHOLD COMPOSITION:

SEX: M=Male, F=Female; RACE: A=African-American, B=Biracial, C=Caucasian, H=Hispanic, N=Native American, P=Pacific Islander or Asian, I=Indochinese, O=Other, U=Unknown; ROLE: V=Child Subject, S=Sibling, P=Parent, F=Foster Parent, R=Relative, L=Paramour, O=Other.

NAME	DOB	ROLE	SEX	RACE	SS#	FACS #	COMMENTS
WATKINS, HEIDE	[REDACTED]	P	F	C	[REDACTED]	[REDACTED]	
DUIS, SHELBY	[REDACTED]	V	F	C	[REDACTED]	[REDACTED]	
MCKNIGHT, TYLER	[REDACTED]	S	M	C	[REDACTED]	[REDACTED]	

NONCUSTODIAL PARENT:

NAME: PHONE:
 ADDRESS:
 PARENTS OF:
 COMMENTS:

PERSON DETERMINED RESPONSIBLE FOR ABUSE: (Only if abuse is confirmed.)

NAME: DOB: SS#: FACS#: RELATIONSHIP:
 ADDRESS: PHONE:
 COMMENTS: WORK PHONE:

ABUSE REPORTED: (Include additional concerns that arise during the course of the assessment.)

Reporter states that Shelby has numerous suspicious injuries.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

██████████

COLLATERALS

██████████ – Small World Day Care – Spirit Lake, IA

Dr. ██████████ – Dickinson County Hospital – Spirit Lake, IA

ASSESSMENT OF CHILD SAFETY:

This worker has expressed my concerns to Heide regarding the number of injuries that Shelby sustained that were unexplainable. However, in talking with Dr. ██████████, this worker has learned that he feels that the explanations given by Heide do account for the injuries. This worker is concerned that Heide needs to provide closer supervision for Shelby as she appears to be accident prone.

SUMMARY OF CONTACTS:

Heide Watkins lives with her two biological children; Shelby Duis and Tyler McKnight.

BODY OF REPORT

On 10-21-99 at 11:00 A.M., this worker received the intake information. The informant stated that Shelby Duis had a number of suspicious injuries where no explanation was given. The informant stated that Shelby Duis was currently at Small World Day Care.

At 12:00 P.M., this worker met face to face with Shelby at Small World Day Care. ██████████

██████████ This worker would like to note that photographs were taken of the injuries and will be contained in the case file. Shelby is, for the most part, non-verbal so is unable to give any explanation at all regarding how she sustained these injuries. Shelby was very agitated while this worker was taking the photographs. This worker would like to note that Shelby has a very swollen thumb and wrist on her right hand. Small World Day Care ██████████, stated that they noticed the swollen hand today and there was no explanation given as to what happened. This worker would like to note that there was also a scratch below Shelby's right ear. ██████████ indicated that injury was noticed today but no explanation was given. This worker would like to note that there were two red marks, which appeared to be bruises, underneath Shelby's right eye. ██████████ stated that those injuries were noticed on Wednesday morning and again Heide never gave an explanation. This worker would like to note that there were several bruises, approximately the size of a dime and greenish in color, on Shelby's back. ██████████ stated that those injuries were noticed on Tuesday. ██████████ stated that Heide questioned her about those injuries. ██████████ stated that Heide wondered if some of the children were trying to pick Shelby up which resulted in Shelby having injuries. ██████████ stated that none of the children were picking Shelby up and she does not feel that any of those bruises were caused at the Small World Day Care Center. Finally, this worker took a picture of Heide's left foot. Specifically, the fourth toe was covered in blood and looked very sore. ██████████ stated that on Tuesday morning they noticed Shelby's toe. ██████████ stated that they were never told anything about the toe and only noticed it after they took Shelby's sock off. ██████████ stated that the toe was covered with dried blood. ██████████ stated that they have been soaking the toe in proxide and they have been putting antibiotic salve and a band-aid on it.

This worker then left messages for Heide Watkins to contact me on three different answering machines. At 3:40 P.M., this worker received a call from Heide Watkins. This worker explained to Heide that I had been out and

visited with Shelby and was very concerned about the number of injuries on Shelby's body. This worker stated to Heide that she needed to take Shelby to either her family physician or the emergency room to have her thumb/wrist looked at. Heide stated to this worker that she did not know that there was anything wrong with Shelby's wrist. Heide stated that if anything happened, it must have happened at Small World. Heide also denied any knowledge about the cut underneath Shelby's ear and the bruising underneath Shelby's eye.

This worker then had contact with [REDACTED] at the Spirit Lake Hospital. [REDACTED] stated that Shelby was seen by Dr. [REDACTED] and would be spending the night in the hospital.

On 10-22-99 at 9:45 A.M., this worker again spoke with [REDACTED] stated that Dr. [REDACTED] did have a chance to meet with Heide Watkins and observe Shelby Duis. This worker stated to [REDACTED] that I would like to come up to the hospital to meet with Heide and Shelby. [REDACTED] stated that she would pass a message on to Heide that I would be coming to meet with her.

At 10:00 A.M., this worker met privately with Heide. This worker first asked Heide about Shelby's thumb. Heide stated that, on Wednesday night, when she picked up Shelby from Small World, there was absolutely no injury on her hand. Heide stated that she does not know exactly what happened to Shelby's hand but the doctor said she does have a broken wrist. Heide stated that the only thing she could think of is that on Wednesday night, she and Shelby were laying in her bed watching TV. Shelby fell asleep. Heide stated that she then put Shelby in her room. Heide stated that she could hear Shelby messing around and later Shelby started screaming. Heide stated that she went in to Shelby's room and Shelby was out of her crib. Heide stated that she did not think much of it and she put Shelby back in her crib. Heide stated that Shelby cried for a little while but then fell asleep. Heide stated that it is not unusual for Shelby to cry when she is put in her crib. Heide stated that the following day, on Thursday, she woke up late and quickly dressed Shelby and took her to day care. Heide stated that she did not specifically look at Shelby's hand or wrist because she had no reason to. Heide stated that she never noticed that there was anything wrong or that it was swollen. Heide stated that Shelby did not complain of her hand hurting and was not crying. This worker stated to Heide that the wrist must have been swollen because when this worker spoke with the Small World Day Care Staff, they stated that as soon as Heide came, they noticed that the wrist was swollen. Heide stated that she is not saying that it was not swollen; she is simply saying that she didn't notice it. Heide stated she had no reason to suspect that Shelby had a swollen wrist. Heide stated to this worker that she did nothing to Shelby to cause her to break her wrist.

This worker then asked Heide about Shelby's ear. Heide stated she does not know how she got the scratch on her ear. Heide stated that Shelby is very active and that it could have happened a number of ways. Heide stated that she did not inflict that injury and it could have been caused [REDACTED]. Heide also stated that Shelby often has nightmares in her sleep. Heide states that she wakes up because Shelby is banging her crib against the wall. Heide stated that, in the past, she has noticed some small scratches on Shelby. Heide again stated that Shelby [REDACTED]. Heide stated that the scratch could have happened any number of ways.

This worker then asked Heide about Shelby's eye. Heide stated that Shelby got a black eye over a week ago. Heide stated that she and Shelby were sitting on her bed and when she got up to make supper, Shelby went to jump off the bed and hit her head on the corner of the night stand. Heide stated that the injuries underneath her eye are still from the black eye fading from that incident. Heide again stated that she did not cause that injury to Shelby. This worker then asked Heide about the bruises on Shelby's back. Heide stated that she did notice those bruises and was quite angry. Heide stated that she called Small World Day Care right away because she thinks that some of the younger kids are trying to pick Shelby up which could result in those bruises. This worker would like to note that the bruises are independent and don't appear to be in any type of pattern. The bruises are approximately the size of a dime and are greenish in color so they have been there awhile. Heide stated that Dr. [REDACTED] asked her about those injuries and she told Dr. [REDACTED] that she honestly did not know how they happened.

This worker then asked Heide about Shelby's toe. Heide stated that she is really not sure when Shelby re-injured her toe. Heide stated that she has had the injured toe for quite some time. Heide stated she does not exactly know how it happened the first time. Heide states that she thinks Shelby may have stubbed it on the legs of the single bed in her room. Heide stated, however, that she really doesn't know if that is how it happened. Heide stated that the original injury is probably two weeks old. Heide stated, however, that Shelby keeps breaking it open because she runs around with no socks on. This worker stated to Heide that Small World said they noticed the injury on Wednesday and it was covered in dried blood. Heide stated that the injury has been there longer than Wednesday. Heide stated that she also treated the injury at home and that, at the beginning of the week, it was looking pretty good. Heide stated that Shelby must have broken it open again and that is why it looks so sore.

At 10:30 A.M., this worker met with [REDACTED]. [REDACTED] stated that she has not noticed any of the injuries until Heide called her and she came to the hospital. [REDACTED] stated that Shelby is very accident prone and is extremely active. [REDACTED] stated that Heide has fallen out of the high chair two times while at Small World Day Care and that she almost bit her tongue off while she was at the Small World Day Care Center. [REDACTED] stated that the only injuries she knew about were the bruises on Shelby's back. [REDACTED] stated that she actually called [REDACTED] at Small World because she has witnessed other kids trying to pick Shelby up. [REDACTED] is now going to provide day care for Shelby and that she guarantees this worker that Shelby will not have half of these injuries that she has now. [REDACTED] stated that she is not accusing Small World Day Care of any type of mistreatment but states that some of those injuries very well could have happened at Small World Day Care. [REDACTED] stated that Heide is not abusing her child. [REDACTED] stated that she knows that with all her heart. [REDACTED] stated that she understands that Heide is a single mother and that maybe the children rough house too much but, in no way, is Heide injuring Shelby.

[REDACTED]

At 10:45 A.M., this worker spoke with Dr. [REDACTED]. Dr. [REDACTED] stated that he has seen all the injuries and has talked to Heide about them. Dr. [REDACTED] and this worker compared explanations that we received from Heide about the injuries. This worker would like to note that they were the same. Dr. [REDACTED] stated that he does not feel any of the injuries were inflicted. Dr. [REDACTED] stated that a fall out of the crib certainly could have caused Shelby to break her wrist. Dr. [REDACTED] stated that the scratch below her ear is minor and that could have happened any number of ways. Dr. [REDACTED] stated that the bruises on Shelby's back are isolated and do not form a pattern. Dr. [REDACTED] stated that he does not know how Shelby received the bruising to her back but, due to the fact that there is no pattern, it suggests that the injuries were likely to be accidental rather than inflicted. Dr. [REDACTED] stated that the injuries underneath Shelby's eyes could be the result of Shelby's black eye healing. Finally, Dr. [REDACTED] stated that Shelby's toe could be the result of an injury by hitting the toe or stubbing the toe. Dr. [REDACTED] stated that there probably needed to be better medical care of the toe so that it would have healed much faster. However, Dr. [REDACTED] stated he does not feel the injury to Shelby's toe was inflicted. Dr. [REDACTED] stated, however, that he was concerned that the injury to Shelby's wrist was not addressed sooner. Dr. [REDACTED] stated that the wrist was bruised and was blue in color. Dr. [REDACTED] stated that the injury had been there at least 24 hours and should have been detected earlier.

This worker spoke with Heide about these concerns and about the fact that the injured wrist was there for quite some time and that, as a parent, she should have noticed it either bathing Shelby or dressing Shelby. This worker stated to Heide that Small World Day Care staff stated that Heide came in the exact same clothes on Thursday that she went home from day care in on Wednesday. Heide admitted that she did not change Shelby's clothes on Thursday morning. This worker spoke with Heide about the fact that this is the [REDACTED] investigation conducted on her as an alleged perpetrator. This worker stated to Heide that [REDACTED]. This worker stated to Heide that I strongly recommended that she accept voluntary in-home services in to her

In the Matter of Iowa Citizens')
Aide/Ombudsman Investigation)
Number: 000565)
)

Subpoena Duces Tecum
State of Iowa
Polk County
Subpoena No.: S-00-004

To: Jessie Rasmussen, Director
Iowa Department of Human Services
Hoover State Office Building
Des Moines, IA 50319

Pursuant to Iowa Code section 2C.9(4), you are hereby commanded to produce at the Office of the Ombudsman, 215 East Seventh Street, Des Moines, Iowa no later than the 18th day of February, 2000 the following items:

Copies of any and all documents and records, in the possession of or maintained by the Iowa Department of Human Services (Department) or its employees or agents, relevant to any contacts or reports to or any actions taken by the Department, its employees or agents regarding alleged child abuse of Shelby Duis. The documents and records shall include, but may not be limited to:

- Intakes or reports alleging abuse (by mandatory and non-mandatory reporters)
- Notes and audiotape recordings by any employee who conducted the child abuse assessments
- Notes by other employees or agents involved in gathering or providing assessment information.
- Notes by any employee involved in reviewing the assessments or assessment reports
- Child Protective Assessment Reports – Parts A and B
- Medical reports concerning Shelby Duis
- Correspondences between the Department and mandatory reporters who made reports

In addition, copies of the following administrative and personnel records:

- Report of the Department's internal investigation of its handling of Shelby Duis' case
- Department's current child protective handbook or manual and related policies or directives
- Child protective policies or practices developed or followed by Sioux City Regional Office
- Documentation or list of the trainings about child protective assessments and services received by employees involved in conducting and reviewing the assessments concerning Shelby Duis.
- Statistics regarding the number of reports denied or accepted for assessments

Records produced in compliance with this subpoena which are confidential by law shall be kept confidential except as provided by law, a court order, or the legal custodian or other person authorized to release such information.

NOTE: Failure to comply with this subpoena may subject you to further proceedings against you in the Iowa District Court.

Feb 10, 2000
Dated


Citizens' Aide/Ombudsman

Phone: 515-281-3592
Toll Free: 1-888-IA-OMBUD
FAX: 515-242-6007
Internet: OMBUD@Legis.State.IA.US



Citizens' Aide/Ombudsman Office
Capitol Complex
215 East Seventh Street
Des Moines, Iowa 50319-0231

home for her and the children. Heide assured this worker that she did not inflict any of the injuries and that she would cooperate with the Department of Human Services in any way possible to help better her as a parent and help to show that she is not inflicting the injuries.

DETERMINATION AS TO WHETHER ABUSE DID OR DID NOT OCCUR: (If registry placement is made, list all factors necessary for this decision, using the Child Protective Handbook.)

This report of Physical Abuse is UNCONFIRMED. In unconfirming this report, this worker has found some of the following factors not to have been met.

FACTOR 1. Shelby Duis is a child, [REDACTED].

FACTOR 2. Heide Watkins is an adult, [REDACTED]. Heide is responsible for caretaker supervision of her daughter, Shelby Duis.

FACTOR 3. A physical injury to the child has occurred. Shelby had a broken right wrist. The wrist was swollen and bruised. Shelby also had a scratch below her right ear. Shelby had two small discolored areas underneath her left eye. Shelby has numerous bruises located on her back. These bruises are about the size of a dime and are greenish in color. These bruises form no specific pattern. Finally, Shelby had an injury to her fourth toe on her left foot.

FACTOR 4. Those injuries appear to be accidental. Heide McKnight Watkins explained that the broken wrist was probably due to Shelby climbing out of her crib and falling to the floor. Dr. [REDACTED], who saw Shelby at the Dickinson Memorial Hospital, stated that is a plausible explanation for the broken wrist.

Heide states she does not know how Shelby received the scratch underneath her ear. Heide stated that it could have happened a number of ways. Heide stated that Shelby [REDACTED] play a lot and that Shelby is very active. Heide stated that it is not uncommon for Shelby to have scratches and bruises.

Heide states that the injury underneath Shelby's eyes are the result of a black eye that Shelby received approximately a week and a half ago falling off her bed and hitting the end table next to her bed. Again, Dr. [REDACTED] stated that the injuries seen on 10-21-99 to Shelby's eyes would be consistent with a healing black eye.

Heide states that she saw the bruising on Shelby's back and was very concerned. Heide stated that she confronted Small World Day Care Center because she believes the bruises are coming from there. Heide states that she feels that the children are trying to pick up Shelby and that is how she is receiving the bruises. Heide was very adamant that she never left the bruises on Shelby's back. This worker would like to note that I am quite puzzled about the bruises on Shelby's back. They are approximately the size of a dime but are in no specific pattern, which would be consistent with a grab mark.

Heide stated that the injury to Shelby's toe is old. Heide states that she honestly does not know how Shelby received the injury to her toe but thinks that Shelby stubbed it on the legs of the legs of her single bed in her room. Heide stated that she has been treating the toe but it continues to break open which makes it look so bad and so sore. Heide stated that she did not inflict any injury to Shelby's toe. Dr. [REDACTED] states that the injury to Shelby's toe could be consistent with Shelby stubbing her toe on the leg of the bed. Dr. [REDACTED] states that this injury could reopen itself causing it to bleed and look very sore.

FACTOR 5. Based on my conversations with Heide and, more importantly my conversations with Dr. [REDACTED], this worker does not feel that the injuries resulted from the acts or omissions of Heide Watkins.

RATIONALE FOR PLACEMENT OR NON-PLACEMENT ON REGISTRY:

This report of Physical Abuse is UNCONFIRMED and is, therefore, not placed on the Child Abuse Registry.

JUVENILE COURT INVOLVEMENT REQUESTED, INCLUDE DATE AND TYPE OF ACTION REQUESTED, IF ANY:
(If action is requested, state date and specific action requested.)

This worker is not making any recommendations for Juvenile Court at this time. Heide has agreed to accept services into her home voluntarily. This worker would like to note that [REDACTED]

[REDACTED]. This worker has ongoing concerns about Heide's drug use and how that affects her supervision of the children. Therefore, this worker has recommended that Heide cooperate with voluntary in-home services. Heide is in agreement to cooperate with these services.

CRIMINAL COURT INVOLVEMENT REQUESTED, INCLUDE DATE AND WHO REFERRED TO IF ANY REQUESTED: (If action is requested, state date, time, and type of action requested.)

This worker is not making any referrals to the Spirit Lake Police Department.

(Rev 7/97)

Attachments (if any, list):

CHUCK ILLG, Child Protection Worker	11/18/1999
Phyllis Slawson	Date
PHYLLIS SLAWSON, Supervisor	11/18/1999
	Date

(Rev 7/97)

Iowa Department of Human Services
CHILD PROTECTIVE ASSESSMENT SUMMARY - Part B
Assessment of the Child and Family Functioning, and Development of Suggested Plan of Action

COMPLETE DATE: 11/18/1999		ADDENDUM DATE:	
INTAKE DATE: 10/21/1999	CHILD PROTECTION WORKER: CHUCK ILLG	INCIDENT: [REDACTED]	COUNTY: DICKINSON
HOUSEHOLD ADDRESS: 1501 JACKSON ST., SPIRIT LAKE, IA 51360			
DIRECTIONS TO HOME:			
TELEPHONES: (Household)		(Other)	
CURRENT LOCATION OF CHILD/SUBJECT:			

TYPE OF ASSESSMENT SUMMARY: Addendum to a previously completed written summary
 HOUSEHOLD COMPOSITION: SEX (M) Male, (F) Female; RACE (A) African-American, (B) Bi-Racial, (C) Caucasian, (H) Hispanic, (N) Native American, (P) Pacific Islander/Asian, (I) Indo-Chinese, (O) Other, (U) Unknown; ROLE (V) Child Subject, (S) Sibling, (P) Parent, (F) Foster Parent, (R) Relative, (L) Paramour, (O) Other.

NAME	DOB	ROLE	SEX	RACE	SS#	FACS#	COMMENTS
WATKINS, HEIDE	[REDACTED]	P	F	C	[REDACTED]	[REDACTED]	
DUIS, SHELBY	[REDACTED]	V	F	C	[REDACTED]	[REDACTED]	
MCKNIGHT, TYLER	[REDACTED]	S	M	C	[REDACTED]	[REDACTED]	

HISTORY OF SERVICES

Heide stated that the only type of therapy or counseling that the family has had is that when she and her first husband divorced, [REDACTED]. Heide stated that she thinks it was offered through the Spirit Lake Elementary School. Heide denies that she has ever been involved with any alcohol or drug treatment classes.

PRESENTING PROBLEM

Heide stated that, lately, she has really been doing very well. Heide stated that she and the children are getting along good and, as a family, they really do not have any problems. Heide stated that she works for her stepfather and she is making a good wage. Heide stated that the children usually listen to her although there are those times when [REDACTED]. Heide stated that her divorce was hard, at first, and it was hard on the whole family. Heide stated that, right after the divorce, she and her ex-husband did not get along but they are getting along better now. Heide stated that her ex-husband has a new girlfriend who is really nice and really good to the children. Heide stated that it sounds weird but, since her ex-husband has started dating his new girlfriend, they are actually able to get along better. Heide stated that she has even gone out with his new girlfriend. Heide stated that she gets [REDACTED]. Heide stated that she has no contact with Shelby's father and does not receive child support. Heide stated that Child Support Recovery is not able to locate Shelby's father. Heide stated that the family does not receive any assistance from the State Of Iowa.

This worker would like to note that there have been concerns in the past about Heide's drug and alcohol use. Heide states that it was a problem in the past but is no longer a problem. However, this worker would like to note that I have received two phone calls stating that Heide is still using. One caller stated that Heide has a drug debt of around \$500.00. The caller would not give any more information so this worker has not been able to follow up on that call. The caller stated that they were not related to Heide in any way and they were calling because they were afraid for Heide's safety. The second caller stated that Heide was using cocaine and crank on the job. The caller stated that some of the employees at work will not ride with Heide because of her usage. [REDACTED]

ASSESSMENT OF THE CHILD AND FAMILY FUNCTIONING: (Describe each of the following, identifying strengths and needs.)

Home Environment:

Heide stated that they moved into the house they are living at now the end of November. Heide stated that she is renting the home from her parents. This worker would like to note that it is an older house but it is very nicely decorated and very nicely kept. The home environment, in no way, poses any danger to Heide's children.

Parent/Caretaker:

Heide stated that she grew up in Spirit Lake, IA. Heide stated that she has five older brothers. Heide stated that her mother and father divorced when she was ten years old. Heide stated that she lived with her mother after the divorce. Heide stated that she and her mother have always been very close and have always gotten along really well together. Heide stated that she dropped out of high school in the eleventh grade. Heide stated that school was really hard for her and that is why she dropped out. Heide stated that if she would have stayed in school, she would have had to retake her freshman year of classes. Heide stated that she moved out of her mother's home two months before she turned eighteen years old. Heide stated that her brother was killed in a helicopter accident in Japan that summer and things were really hard that summer for both her and her mother. Heide stated that when all of that was going on, she decided to move out of the home. Heide stated that she married Troy McKnight in 1990. Heide stated that the two of them lived together a year before they were married. Heide stated that the divorce was finalized in 1998 though the two of them separated in 1994. Heide stated that she and Troy's marriage did not work [REDACTED].

[REDACTED]. Heide stated that she and Kevin Duis, Shelby's father, started to live together in 1995. Heide stated that that relationship ended in early 1997 before Shelby was even born. Heide stated that that relationship did not work because Kevin was a creep. Heide stated that Kevin has only seen Shelby twice and that is when she was a very young baby. Heide states that she works for Moritz' Construction and she has worked there for the past five years. Heide stated she has a good boss because her stepfather owns the company. Heide stated that she enjoys riding bikes with her children and she enjoys going water skiing. Heide also stated that she has a friend that has a boat so she and the children enjoy boating in the summer together. Heide also states that she likes to take the children to the park so that they can play. Heide stated that her best qualities are that she is a hard worker and she is a good mother. Heide stated that she is really easy to get along with. When this worker asked Heide what she would change about herself, Heide stated that she may be a little too lenient when it comes to discipline. Heide stated that her job is very demanding and physically tiring. Heide stated that sometimes she is just too tired to deal with the children's behaviors. This worker then talked with Heide about drug use. This worker would like to note that, in the past, this worker has always had a concern about Heide abusing drugs. Heide admitted that there was some drug use in the past. Heide denied that there is any drug use currently. Frankly, this worker is very suspicious of whether or not Heide is being honest.

Domestic Violence:

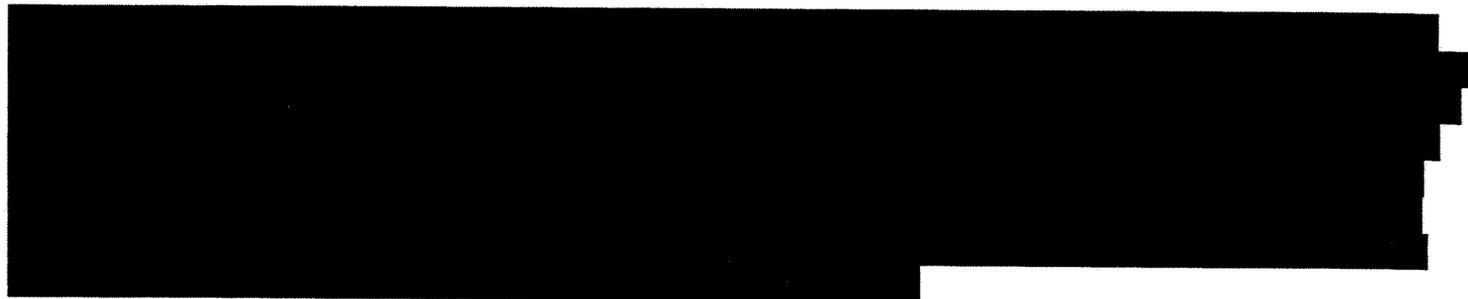
Heide stated that there has never been any domestic violence in any of her relationships.

Substance Abuse:

Heide has admitted that there used to be a problem with drugs and alcohol but states that those issues are resolved. This worker would like to note, however, that I continue to hear concerns.

Child(ren): (Include all children in home.)

Heide stated that Shelby goes to Small World Day Care. Shelby stated that she thinks that Small World does a really good job with Shelby. Heide stated that Shelby has gone there since right after she was born. Heide stated that Shelby is very active and is a smiley child. Heide stated that Shelby is always on the go and is always running through the house. Heide stated that Shelby will climb on anything she finds. Heide stated that Shelby is in good health and has never had any serious medical problems.



Social/Environment:

Heide stated that the family does not belong to any groups, organizations, or church. [REDACTED]. Heide stated that she can always count on her mother and stepfather to help her out if things get tough. Heide again stated that she and her mother have always been very close and have always had a very good relationship. Heide also stated that she is close to her biological father who lives in Spirit Lake, IA. Heide stated that one of her closet friends is [REDACTED] and that she can always count on [REDACTED] to help her out. This worker would like to note that [REDACTED] is a known drug user and has been incarcerated because of drug use. Heide stated that [REDACTED]. Heide stated that she has to go to work early in the morning so her mother comes over and gets Tyler and Shelby up and ready for the day. Shelby used to go to Small World Day Care, however, Shelby now goes to [REDACTED] home. [REDACTED]

Analysis of Family Functioning:

This worker likes Heide. Heide has always been cooperative with this worker though I question her honesty at times. Heide is a very hard worker and truly loves her children. However, in the past, Heide has made some bad choices regarding her lifestyle. To put it simply, this worker is very concerned about Heide's drug use and how it affects her children. Heide has so many positive traits that this worker would hate to see them diminished because of addiction. Heide denies drug use but this worker continues to have concerns about it.

SUGGESTED PLAN OF ACTION: (Provide rationale for any of the following suggested plans of action recommended, indicate with a N/A if the section is not applicable.)

Identification/Development of Informal Supports for Child and/or Family (if any):

Heide stated to this worker that she has lived in the Spirit Lake area all her life and has worked for her stepfather for the past five years. Heide stated that the family is very active and are always on the go. Heide states that she is very close to her biological father, her biological mother, and her stepfather.

Heide stated that she has friends that will help her out when she is in need. This worker is concerned that Heide's friends, such as [REDACTED], are not the types of support Heide needs. This worker would like to see Family Centered Services work on building appropriate informal supports.

Identification/Development of Services Provided by Community Agencies or Organizations (if any):

Again, Heide stated that she has lived in Spirit Lake, IA, all her life. Heide stated that she is active in the community though she doesn't belong to any specific groups, organizations, or church. Heide has taken advantage of community agencies/organizations to help benefit she and her children. Heide stated that [REDACTED] Heide stated that [REDACTED]

[REDACTED] It appears that this family is utilizing community agencies and supports for the betterment of their family.

Department Services Provided and Recommendations (if any):

This worker has spoken with Heide about accepting voluntary in home services. Heide has agreed to cooperate with these services. Heide will benefit from services that help her cope as a single mother.

The other recommendation this worker has is that Heide agree to random drug tests to be performed by the Department of Human Services. This is something that Heide should not object to as she has stated that she no longer uses illegal drugs.

CHUCK ILLG, Child Protection Worker
Phyllis Slawson

PHYLLIS SLAWSON, Supervisor

11/18/1999

Date
11/18/1999

Date

(Rev 7/97)

Iowa Department of Human Services

CHILD PROTECTIVE ASSESSMENT SUMMARY PART A

REPORT INFORMATION:

Completion Date: 01/04/2000

Addendum Date:

Intake Date: 12/02/1999 Child Protection Worker: CHUCK ILLG

Incident: [REDACTED]

County: DICKINSON

Household Address: 1501 JACKSON ST., SPIRIT LAKE, IA 51360

Directions to Home:

Telephones: (Household) (Other)

Current Location of Child/Subject:

TYPE OF ASSESSMENT SUMMARY:

Non-Registered Registered Addendum to a previously completed written summary

HOUSEHOLD COMPOSITION:

SEX: M=Male, F=Female; RACE: A=African-American, B=Biracial, C=Caucasian, H=Hispanic, N=Native American, P=Pacific Islander or Asian, I=Indochinese, O=Other, U=Unknown; ROLE: V=Child Subject, S=Sibling, P=Parent, F=Foster Parent, R=Relative, L=Paramour, O=Other

NAME	DOB	ROLE	SEX	RACE	SS#	FACS #	COMMENTS
WATKINS, HEIDE	[REDACTED]	P	F	C	[REDACTED]	[REDACTED]	
DUIS, SHELBY	[REDACTED]	V	F	C	[REDACTED]	[REDACTED]	
MCKNIGHT, TYLER	[REDACTED]	S	M	C	[REDACTED]	[REDACTED]	

NONCUSTODIAL PARENT:

NAME: PHONE:
 ADDRESS:
 PARENTS OF:
 COMMENTS:

PERSON DETERMINED RESPONSIBLE FOR ABUSE: (Only if abuse is confirmed.)

NAME: DOB: SS#: FACS#: RELATIONSHIP:
 ADDRESS: PHONE:
 COMMENTS: WORK PHONE:

ABUSE REPORTED: (Include additional concerns that arise during the course of the assessment.)

Reporter states that Shelby has a cigarette burn on her stomach. Reporter also states that Shelby fell down the stairs. Reporter states that there is no known perpetrator for the cigarette burn.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

████████████████████
████████████████████

COLLATERALS

████████████████████ – Spirit Lake, IA 51360

ASSESSMENT OF CHILD SAFETY:

This worker would like to note that after meeting with Heide, Shelby, Tyler, and ██████████, this worker learned that the injuries were not inflicted. Shelby does not have a cigarette burn on her stomach. Shelby did not fall down the steps and receive an injury. This worker has referred the family for Family Centered Services. Heide is currently working with Deb Nelson, Social Worker II, Dickinson County Department of Human Services. As long as Heide continues to cooperate with Deb Nelson, this worker does not have any concerns regarding the children's safety.

SUMMARY OF CONTACTS:

Heide Watkins lives with her two biological children; Shelby Duis and Tyler McKnight.

BODY OF REPORT

On 12-2-99 at 9:30 A.M., this worker received the intake information. The informant stated that Shelby had a cigarette burn on her stomach and had two black eyes from falling down the stairs. The informant stated that they did not know who inflicted the cigarette burn on Shelby.

At 10:00 A.M., this worker attempted to contact ██████████. This worker knows, from previous contact with the family, that ██████████ provides day care for Shelby Duis. This worker attempted to contact ██████████ at 10:00 A.M., 10:50 A.M., 11:26 A.M., 11:55 A.M., and 1:00 P.M.

At 2:40 P.M., this worker was able to reach ██████████ at work. This worker explained the concerns to ██████████. This worker stated to ██████████ that I needed to see Shelby on this date due to the allegation that she had a cigarette burn on her stomach. ██████████ stated to this worker that Shelby does not have a cigarette burn on her stomach. ██████████ stated that the injury on Shelby's stomach was inflicted by Shelby. ██████████ also stated that Shelby fell and hit a box in her home and that is why her eyes were discolored. ██████████ stated that Heide has the day off and that Shelby was at Heide's home.

This worker was unable to make contact with Heide on this date.

On 12-3-99 at 10:30 A.M., this worker did meet face to face with Heide's family as well as ██████████ at ██████████ home. ██████████ then showed me exactly where the Fisher Price box was in her home. ██████████ laid everything out the way it was when Shelby tripped and fell on the box. ██████████ showed me where the plastic bag full of other Christmas stuff was on the floor. ██████████ then showed me how Shelby tripped on the plastic bag and fell and hit her face on the box. This worker then asked ██████████ about the allegation of Shelby falling down the steps. ██████████ stated that Shelby slipped down the last two steps to the doorway. ██████████ stated that that did not cause any injury. ██████████ stated that Shelby has slipped down the last step or two before. ██████████ showed the stairway and the stairway is carpeted. ██████████ stated that Shelby got her bruise by hitting the box. ██████████ stated that when her dryer goes off, Shelby always runs to the dryer and then yells at her to come get the clothes.

RATIONALE FOR PLACEMENT OR NON-PLACEMENT ON REGISTRY:

This report of Physical Abuse is UNCONFIRMED and is, therefore, not placed on the Child Abuse Registry.

JUVENILE COURT INVOLVEMENT REQUESTED, INCLUDE DATE AND TYPE OF ACTION REQUESTED, IF ANY:
(If action is requested, state date and specific action requested.)

Currently, Heide is working with Deb Nelson, Social Worker II, Dickinson County Department of Human Services. As long as Heide continues to fully cooperate with services, this worker will not be making a recommendation for Juvenile Court.

However, in the event that Heide does not keep scheduled appointments, this worker will strongly consider a Child In Need Of Assistance Petition on [REDACTED] Shelby Duis [REDACTED]

CRIMINAL COURT INVOLVEMENT REQUESTED, INCLUDE DATE AND WHO REFERRED TO IF ANY REQUESTED: (If action is requested, state date, time, and type of action requested.)

This worker is not making a referral to law enforcement regarding this allegation.

(Rev 7/97)

Attachments (if any, list):

CHUCK ILLG, Child Protection Worker	01/04/2000 Date
Phyllis Slawson	01/04/2000
PHYLLIS SLAWSON, Supervisor	Date

(Rev 7/97)

Iowa Department of Human Services
CHILD PROTECTIVE ASSESSMENT SUMMARY - Part B
Assessment of the Child and Family Functioning, and Development of Suggested Plan of Action

COMPLETE DATE: 01/04/2000		ADDENDUM DATE:	
INTAKE DATE: 12/02/1999	CHILD PROTECTION WORKER: CHUCK ILLG	INCIDENT: [REDACTED]	COUNTY: DICKINSON
HOUSEHOLD ADDRESS: 1501 JACKSON ST., SPIRIT LAKE, IA 51360			
DIRECTIONS TO HOME:			
TELEPHONES: (Household)		(Other)	
CURRENT LOCATION OF CHILD/SUBJECT:			

TYPE OF ASSESSMENT SUMMARY: Addendum to a previously completed written summary
HOUSEHOLD COMPOSITION: SEX (M) Male, (F) Female; RACE (A) African-American, (B) Bi-Racial, (C) Caucasian, (H) Hispanic, (N) Native American, (P) Pacific Islander/Asian, (I) Indo-Chinese, (O) Other, (U) Unknown; **ROLE** (V) Child Subject, (S) Sibling, (P) Parent, (F) Foster Parent, (R) Relative, (L) Paramour, (O) Other.

NAME	DOB	ROLE	SEX	RACE	SS#	FACS#	COMMENTS
WATKINS, HEIDE	[REDACTED]	P	F	C	[REDACTED]	[REDACTED]	
DUIS, SHELBY	[REDACTED]	V	F	C	[REDACTED]	[REDACTED]	
MCKNIGHT, TYLER	[REDACTED]	S	M	C	[REDACTED]	[REDACTED]	

HISTORY OF SERVICES

PRESENTING PROBLEM

Heide stated that, lately, she has really been doing very well. Heide stated that she and the children are getting along good and, as a family, they really do not have any problems. Heide stated that she works for her stepfather and she is making a good wage. Heide stated that the children usually listen to her though there are those times when [REDACTED]

[REDACTED] Heide stated that her divorce was hard, at first, and it was hard on the whole family. Heide stated that, right after the divorce, she and her ex-husband did not get along but they are getting along better now. Heide stated that her ex-husband has a new girlfriend who is really nice and really good to the children. Heide stated that it sounds weird but, since her ex-husband has started dating his new girlfriend, they are actually able to get along better. Heide stated that she has even gone out with his new girlfriend. Heide stated that she gets [REDACTED]. Heide stated that she has no contact with Shelby's father and does not receive child support. Heide stated that Child Support Recovery is not able to locate Shelby's father. Heide stated that the family does not receive any assistance from the State of Iowa.

This worker would like to note that there have been concerns in the past about Heide's drug and alcohol use. Heide states that it was a problem in the past but is no longer a problem. Heide is currently working with in home services.

ASSESSMENT OF THE CHILD AND FAMILY FUNCTIONING: (Describe each of the following, identifying strengths and needs.)

Home Environment:

Heide stated that they moved into the house they are living at now the end of November. Heide stated that she is renting the home from her parents. This worker would like to note that it is an older house but it is very nicely decorated and very nicely kept. The home environment, in no way, poses any danger to Heide's children.

Parent/Caretaker:

Heide stated that she grew up in Spirit Lake, IA. Heide stated that she has five older brothers. Heide stated that her mother and father divorced when she was ten years old. Heide stated that she lived with her mother after the divorce. Heide stated that she and her mother have always been very close and have always gotten along really well together. Heide stated that she dropped out of high school in the eleventh grade. Heide stated that school was really hard for her and that is why she dropped out. Heide stated that if she would have stayed in school, she would have had to retake her freshman year of classes. Heide stated that she moved out of her mother's home two months before she turned eighteen years old. Heide stated that her brother was killed in a helicopter accident in Japan that summer and things were really hard that summer for both her and her mother. Heide stated that when all of that was going on, she decided to move out of the home. Heide stated that she married Troy McKnight in 1990. Heide stated that the two of them lived together a year before they were married. Heide stated that the divorce was finalized in 1998 though the two of them separated in 1994. Heide stated that she and Troy's marriage did not work [REDACTED]. Heide stated that she and Kevin Duis, Shelby's father, started to live together in 1995. Heide stated that that relationship ended in early 1997 before Shelby was even born. Heide stated that that relationship did not work because Kevin was a creep. Heide stated that Kevin has only seen Shelby twice and that is when she was a very young baby. Heide states that she works for Moritz' Construction and she has worked there for the past five years. Heide stated she has a good boss because her stepfather owns the company. Heide stated that she enjoys riding bikes with her children and she enjoys going water skiing. Heide also stated that she has a friend that has a boat so she and the children enjoy boating in the summer together. Heide also states that she likes to take the children to the park so that they can play. Heide stated that her best qualities is that she is a hard worker and she is a good mother. Heide stated that she is really easy to get along with. When this worker asked Heide what she would change about herself. Heide stated that she might be a little too lenient when it comes to discipline. Heide stated that her job is very demanding and physically tiring. Heide stated that sometimes she is just too tired to deal with the children's behaviors. This worker then talked with Heide about drug use. This worker would like to note that, in the past, this worker has always had a concern about Heide abusing drugs. Heide denied that there is any drug use currently.

Domestic Violence:

Heide stated that there has never been any domestic violence in any of her relationships.

Substance Abuse:

Heide has admitted that there used to be a problem with drugs and alcohol but states that those issues are resolved. This worker would like to note however, I continue to hear concerns.

Child(ren): (Include all children in home.)

Heide stated that Shelby used to go to Small World Day Care. However, Shelby is now cared for by [REDACTED]. Heide stated that Shelby is very active and is a smiley child. Heide stated that Shelby is always on the go and is always running through the house. Heide stated that Shelby will climb on anything she finds. Heide stated that Shelby is in good health and has never had any serious medical problems. This worker has noticed a big change in Shelby's vocabulary since the daycare change was made. Shelby still appears to be delayed with her speech but is starting to talk in sentences.

[REDACTED]

Social/Environment:

Heide stated that the family does not belong to any groups, organizations, or church. [REDACTED] Heide stated that she can always count on her mother and stepfather to help her out if things get tough. Heide again stated that she and her mother have always been very close and have always had a very good relationship. Heide also stated that she is close to her biological father who lives in Spirit Lake, IA. Heide stated that, one of her closet friends is [REDACTED] and that she can always count on [REDACTED] to help her out. [REDACTED]. Heide stated that she has to go to work early in the morning so her mother comes over and gets Tyler and Shelby up and ready for the day. Heide stated that her mother then takes Tyler to school and then takes Shelby to her home.

SUGGESTED PLAN OF ACTION: (Provide rationale for any of the following suggested plans of action recommended, indicate with a N/A if the section is not applicable.)

Identification/Development of Informal Supports for Child and/or Family (if any):

Heide stated to this worker that she has lived in the Spirit Lake area all her life and has worked for her stepfather for the past five years. Heide stated that the family is very active and are always on the go. Heide states that she is very close to her biological father, her biological mother, and her stepfather. Heide stated that she has friends that will help her out when she is in need. This worker would like to note that, at this point in time, this worker has no specific recommendations for any additional informal supports to be developed. Heide has accepted in home services, which will help develop informal supports.

Identification/Development of Services Provided by Community Agencies or Organizations (if any):

Again, Heide stated that she has lived in Spirit Lake, IA, all her life. Heide stated that she is active in the community though she doesn't belong to any specific groups, organizations, or church. Heide has taken advantage of community agencies/organizations to help benefit she and her children. Heide stated that her mother comes over every morning and helps gets Tyler and Shelby up. Heide stated, in the summer time, [REDACTED]. It appears that this family is utilizing community agencies and supports for the betterment of their family.

Department Services Provided and Recommendations (if any):

After assessing the informal supports and the community supports, this worker has made a recommendation for services to be provided by the Department of Human Services. Heide has agreed to voluntarily work with in home services.

CHUCK ILLG, Child Protection Worker
Phyllis Slawson
PHYLLIS SLAWSON, Supervisor

01/04/2000
Date
01/04/2000
Date

(Rev 7/97)

COUNTY Dickinson

DON'T EVER GIVE OUT A CASE WORKER'S NAME OR PHONE NUMBER TO ANY CALLER

CHILD - DEPENDENT ADULT PROTECTIVE INVESTIGATIONS CONTACT REPORT

DAY Sun DATE 12-12 TIME START 9:36 pm TIME END 9:42 HOTLINE WORKER Chris

CALLER'S NAME Sheri CALLER'S PHONE 712-336-4460

ADDRESS _____ ANONYMITY YES NO

CITY Spirit Lake STATE IA ZIP CODE _____

NAME OF CHILD/ADULT _____ AGE _____ DOB _____

1. Shelby (Not Sure of Last Name) 3

2. _____

3. _____

4. _____

5. _____

Ref

WHERE IS VICTIM RIGHT NOW _____

WHERE DID ABUSE TAKE PLACE _____

PHYSICAL SEXUAL DENIAL OF CRITICAL CARE (NEGLECT)

SUSPECTED ABUSER Jessie

ADDRESS Corner of 15th & Jackson CITY Spirit Lake STATE IA

PHONE 712-336-9774 RELATION TO VICTIM Boyfriend

PARENT/GUARDIAN Heidi Watkin

ADDRESS Corner of 15th & Jackson CITY Spirit Lake STATE _____

PHONE 712-336-9774 RELATION TO VICTIM Mother

DESCRIPTION OF ABUSE _____

Two Black eyes & Facial Contusions
Bruising & open sores on genitalia. Bruising on
legs & stomach. Possible Concussion

ER. is Calling Back

SOCIAL WORKER Carri TIME CALLED 9:43

PHONE NUMBER 1 888-326-7243 ext 6549 CALL RETURNED 9:46

IF NOT RESPONDED TO IN 15 MINUTES..... PAGE WORKER AGAIN

Appendix I

Iowa Department of Human Services

CHILD PROTECTIVE ASSESSMENT SUMMARY PART A

REPORT INFORMATION:

Completion Date: 02/04/2000
 Intake Date: 01/04/2000 Child Protection Worker: CHUCK ILLG
 Household Address: 1501 JACKSON ST., SPIRIT LAKE, IA 51360

Addendum Date:
 Incident: [REDACTED] County: DICKINSON

Directions to Home:
 Telephones: (Household) (Other)
 Current Location of Child/Subject:

TYPE OF ASSESSMENT SUMMARY:

Non-Registered Registered Addendum to a previously completed written summary

HOUSEHOLD COMPOSITION:

SEX: M=Male, F=Female; RACE: A=African-American, B=Biracial, C=Caucasian, H=Hispanic, N=Native American, P=Pacific Islander or Asian, I=Indochinese, O=Other, U=Unknown; ROLE: V=Child Subject, S=Sibling, P=Parent, F=Foster Parent, R=Relative, L=Paramour, O=Other.

NAME	DOB	ROLE	SEX	RACE	SS#	FACS #	COMMENTS
WATKINS, HEIDE	[REDACTED]	P	F	C	[REDACTED]	[REDACTED]	
WENDELSDORF, JESSE	[REDACTED]	L	M	C	[REDACTED]	[REDACTED]	
DUIS, SHELBY	[REDACTED]	V	F	C	[REDACTED]	[REDACTED]	
MCKNIGHT, TYLER	[REDACTED]	S	M	C	[REDACTED]	[REDACTED]	

NONCUSTODIAL PARENT:

NAME: DUIS, KEVIN PHONE:
 ADDRESS: 224 S. OKOBOJI GR. RD, BOX 836, ARNOLDS PARK, IA 51331
 PARENTS OF:
 COMMENTS:

PERSON DETERMINED RESPONSIBLE FOR ABUSE: (Only if abuse is confirmed.)

NAME: WATKINS, HEIDE DOB: [REDACTED] SS#: [REDACTED] FACS#: [REDACTED]	RELATIONSHIP: PARENT
ADDRESS: 1501 JACKSON ST., SPIRIT LAKE, IA 51360	PHONE:
COMMENTS:	WORK PHONE:
NAME: WENDELSDORF, JESSE DOB: [REDACTED] SS#: [REDACTED] FACS#: [REDACTED]	RELATIONSHIP: PARAMOUR
ADDRESS: 1501 JACKSON ST., SPIRIT LAKE, IA 51360	PHONE:
COMMENTS:	WORK PHONE:

ABUSE REPORTED: (Include additional concerns that arise during the course of the assessment.)

Reporter states that Shelby was found dead in her bed on 1-4-2000. Reporter states that Shelby appeared to have multiple unexplained injuries. Shelby also had physical evidence of sexual abuse.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

COLLATERAL CONTACTS

Dickinson County Sheriff's Department – Spirit Lake, IA

Spirit Lake Police Department – Spirit Lake, IA

Dr. [REDACTED] – Sioux Valley Hospital – Sioux Falls, South Dakota

Dr. [REDACTED] – Spirit Lake, IA

Deb Nelson – Dickinson County DHS, SWII – Spirit Lake, IA

Heather Wright – Crittenton Center – [REDACTED], Sioux City, IA

[REDACTED] – Spirit Lake, IA

ASSESSMENT OF CHILD SAFETY:

Shelby Duis was found dead lying in the bed [REDACTED]

[REDACTED]

SUMMARY OF CONTACTS:

Heide McKnight lived in her home with her son, Tyler McKnight; and her daughter, Shelby Duis. Also living in the home was Heide's paramour, Jesse Wendelsdorf. This worker would like to note that prior to 1-4-2000, Heide denied to Deb Nelson, Heather Wright ([REDACTED] worker), and myself that anyone else was living in the family home.

BODY OF REPORT

On 1-4-2000 at 5:45 P.M., this worker received the intake information stating that Shelby Duis was found dead in her bed [REDACTED], at around 4:00 P.M.

At 5:48 P.M., this worker spoke with [REDACTED] of the Dickinson County Sheriff's Department. [REDACTED] stated that Shelby appears to have multiple injuries. [REDACTED] requested that this worker drive to Spirit Lake to assist in the investigation regarding Shelby's death.

At 6:10 P.M., this worker met face to face with [REDACTED] at the Dickinson County Sheriff's Department. When this worker arrived at the Sheriff's Department, the deputies were interviewing Jesse Wendelsdorf, Heide Watkins' paramour. [REDACTED] stated that Heide was being interviewed over at the police department.

At 6:50 P.M., this worker drove to the Watkins' home. This worker would like to note that Officer [REDACTED] was at the family home securing the scene. This worker would like to note that Shelby was lying on the floor when this worker arrived at the home. Officer [REDACTED] stated that the paramedics laid Shelby on the floor in their attempt to do a medical assessment. This worker would like to note that Shelby did appear to have multiple facial injuries as well as blood in her mouth. This worker immediately asked Officer [REDACTED] where Tyler McKnight was. [REDACTED]

At 7:08 P.M., this worker drove to the Spirit Lake Police station. When this worker arrived at the police station, Officer [REDACTED] and [REDACTED] were conducting an interview with Heide Watkins.

At 7:30 P.M., Officer [REDACTED], [REDACTED], and this worker conducted an interview with [REDACTED] by Shelby. [REDACTED] was asked about previous concerns about injuries suffered by Shelby. [REDACTED] was then asked questions to help establish a time line for the events that took place on 1-3-2000 and 1-4-2000. [REDACTED] stated that she talked to Heide on 1-3-2000 and again on 1-4-2000. [REDACTED] was asked what injuries she noticed on Shelby the last time she saw Shelby. [REDACTED] stated that Shelby had some discoloration around her eyes as well as a bruise on her forehead. [REDACTED] stated that is the only injuries that she noticed on Shelby other than her bad diaper rash. [REDACTED] stated that, on 1-4-2000, she received a phone call from Heide saying that she could not wake Shelby up. [REDACTED] stated that Heide was very frantic so she hung up the phone and told her husband, [REDACTED], they to go to Heide's home. [REDACTED] stated that she thought that phone call occurred around 4:00 P.M.

At 8:45 P.M., this worker met face to face with Tyler McKnight [REDACTED]
[REDACTED]
[REDACTED]

After my interview with Tyler McKnight, this worker drove back to the Spirit Lake Police Department. At that time, the deputies from the Dickinson County Sheriff's Department, the police officers from the Spirit Lake Police Department, and [REDACTED] from the Department of Criminal Investigations, sat down and went over the notes regarding the interviews. The following is a combination of the time lines given by Jesse, Heide, and Tyler. On Monday, 1-3-2000, it appears that Heide was home most of the evening by herself. A family friend, [REDACTED], did stop over at the home. Jesse did spend the night at Heide's home and this worker is unsure of what time he arrived back in the home. [REDACTED] Shelby went to bed [REDACTED] around 9:00 P.M. that evening.

On 1-4-2000, Tyler woke up and got ready, by himself, to go to school. Jesse was in the home but left for work before Tyler left the home. Jesse went to work and returned home around 12:00 P.M. or 12:30 P.M. At that time, Jesse, Heide, and Shelby were the only ones in the family home. Tyler then returned home from school and played outside for a little bit and then came in to the family home and watched TV. Jesse then received a phone call and left the home around 4:00 P.M. Heide had been in the home all day long and stated that she would check on Shelby by moving back a curtain that covered the door way to look at her. Shelby remained in her bed from 9:00 P.M. on 1-3-2000 until Heide attempted to wake her up around 4:15 P.M. to go to her doctor's appointment. At that time, Heide found Shelby not breathing. This worker would like to note that Shelby was seen by Dr. [REDACTED] in Spirit Lake, IA, on 1-3-2000 at approximately 5:15 P.M.

On 1-5-2000, this worker spoke with Deb Nelson, SWII in Dickinson County. This worker explained to Deb that Shelby Duis was found dead at her home on 1-4-2000. Deb and this worker talked about her contacts with the family as well as the [REDACTED] worker's contacts. Heather Wright, from the Crittenton Center was providing services to the family. Heather's first face to face contact with the family was on 12-23-99. On that date, Deb Nelson was unable to get a hold of Heather to explain to Heather that this worker had received concerns about Shelby having a bruise on her forehead and discoloration around her eyes. Deb was also unable to explain to Heather that this worker also received a concern about Shelby having a rash on her genital area. Deb, however, was able to speak with Heide on this date and Heide assured Deb that she would show Heather the bruise on her forehead as well as the rash to her genital area.

This worker would also like to note that I spoke with Heide, on or about 12-17-99, and urged her to have Shelby seen by a physician. I explained to Heide that our office continued to receive calls about the injury to Shelby's forehead and that there was a concern that Shelby had a rash on her vaginal area. Heide stated that she would take Shelby to the doctor. On 12-23-99, this worker called Deb Nelson to ask her if she could follow up on whether or not Heide followed through with having Shelby seen at the doctor's office. Deb made contact with Heide and Heide stated that she could not get an appointment on that date. This worker would like to note that I also spoke with Heide on that date and was given the same explanation. I did contact the doctor's office and was told that they could not tell me if Heide had called for an appointment or not. They did state that the doctors in the office were booked on that date. This worker urged Heide to have Shelby seen as soon as possible.

On 12-29-99, this worker learned from Deb Nelson that Shelby still had not been seen by a doctor. This worker then wrote Heide a letter stating if Shelby was not seen by a doctor by 1-3-2000 at 4:30pm, I would send a copy to the County Attorneys Office. Heide called this worker on 1-3-2000 and stated she had an appointment for Shelby at 5:00pm.

On 1-5-2000 at 1:00 P.M., this worker spoke with Dr. [REDACTED] by phone. Dr. [REDACTED] and this worker talked about his examination of Shelby Duis. Dr. [REDACTED] confirmed that he did see Shelby on 1-3-2000 and had scheduled another appointment to see her on 1-4-2000. Dr. [REDACTED] stated that on 1-4-2000, he was going to do some blood work on Shelby because Heide expressed a concern that she may be anemic and that she seemed to bruise easily. Dr. [REDACTED] stated that he examined Shelby's injury to her forehead as well as diagnosed Shelby as having a rash on her genital area. Dr. [REDACTED] stated he prescribed medication to clear up Shelby's genital rash. He stated that six months ago Shelby had a similar rash located on her inner thigh that responded positively to the medication.

[REDACTED]

[REDACTED]

On 1-18-2000 at 10:30 A.M., this worker, as well as [REDACTED]; Officer [REDACTED]; and [REDACTED], drove to the Sioux Valley Hospital in Sioux Falls, South Dakota, to meet with Dr. [REDACTED]. Dr. [REDACTED] has a multi-disciplinary team that meets to staff difficult cases in which children are seriously injured or cases which result in a child's death. Dr. [REDACTED] was able to review the autopsy report conducted by Dr. [REDACTED] in Sioux Falls, S.D. Dr. [REDACTED] helped explain the findings of the autopsy report. This worker would like to note that there were numerous injuries found on Shelby Duis' body, including the

injury to Shelby's forehead, which was investigated on 12-3-99. Dr. [REDACTED] stated that the injury to Shelby's forehead could be explained as an accidental injury. Dr. [REDACTED] did indicate, however, that a majority of these injuries were inflicted and caused by blunt trauma. Dr. [REDACTED] ruled out the possibility of these injuries being accidental. Dr. [REDACTED] also stated there was evidence of sexual abuse trauma, which would have occurred within the last 24 hours of Shelby's life.

On 1-20-2000, this worker sent certified letters to Heide Watkins [REDACTED]. This worker also sent two certified letters to Jesse Wendelsdorf; one to him and Heide's residence and one to his parent's residence. This worker would like to note Jesse's certified mail was returned to this office as Jesse had been arrested and charged with murder in the first degree as well as sexual abuse. Jesse is currently being held in the Clay County Jail.

On 1-24-2000, this worker received a phone message left by [REDACTED] on 1-22-2000. [REDACTED] stated, via voice mail, that, at this point in time, Heide was waiving her right to be interviewed by this worker. [REDACTED] stated that there would no interview between this worker and Heide Watkins at this time.

On 1-28-2000, this worker spoke with [REDACTED]. [REDACTED] stated that Jesse was not going to meet with this worker at this time regarding the interview.

This worker would like to note that there is an on-going criminal investigation. If more is discovered it will be added to this report in the form of an addendum.

DETERMINATION AS TO WHETHER ABUSE DID OR DID NOT OCCUR: (If registry placement is made, list all factors necessary for this decision, using the Child Protective Handbook.)

This report of Physical Abuse is **CONFIRMED**. All of the following necessary factors have been met by the required preponderance of the credible evidence.

FACTOR 1. Shelby Duis is a child, [REDACTED].

FACTOR 2. Heide Watkins is an adult, [REDACTED]. Heide was responsible for caretaker supervision of her daughter, Shelby Duis.

FACTOR 3. Shelby Duis died on 1-4-2000. The autopsy report shows that there were several injuries. Some of the injuries occurred to Shelby in the last 24 hours of her life and other injuries were older in nature. Dr. [REDACTED], who did the autopsy, as well as Dr. [REDACTED] that reviewed the autopsy, state that a majority of these injuries were inflicted injuries. Both Dr. [REDACTED] and Dr. [REDACTED] ruled out accidental explanation for a majority of the old and new injuries that Shelby had.

FACTOR 4. Dr. [REDACTED] and Dr. [REDACTED] stated that the majority of the injuries found on Shelby at the time of the autopsy were inflicted injuries and, in no way, could be explained as being accidental. Dr. [REDACTED] and Dr. [REDACTED] found inflicted injuries, which would have occurred within the last 24 hours of Shelby's life. Dr. [REDACTED] and Dr. [REDACTED] also found older inflicted injuries on Shelby's body.

FACTOR 5. Based on the statements from Dr. [REDACTED] and Dr. [REDACTED], a majority of the injuries found on Shelby's body were inflicted and; therefore, resulted from the acts or omissions of the responsible caretakers. Heide had caretaker responsibility for Shelby. Both Jesse and Heide lived in the family home together. Both Jesse and Heide are either responsible for causing the injuries themselves or they are responsible for not preventing the other from inflicting the injuries on Shelby Duis. During Shelby's last 24 hours of her life, the

only two caretakers to have any contact with Shelby were Jesse Wendelsdorf and Heide Watkins. Dr. [REDACTED] and Dr. [REDACTED] state that there were a number of injuries that occurred within the last 24 hours of Shelby's life that could not be explained accidentally. These injuries were inflicted.

Shelby Duis is listed as the victim in this allegation. Heide Watkins is listed as the person responsible for the abuse in this allegation.

This report of Physical Abuse is **CONFIRMED**. All of the following necessary factors have been met by the required preponderance of the credible evidence.

FACTOR 1. Shelby Duis is a child, [REDACTED].

FACTOR 2. Jesse Wendelsdorf, is an adult, [REDACTED]. Jesse is Heide Watkins' paramour and lived in the family home. Jesse was also responsible for caretaker supervision of Shelby Duis.

FACTOR 3. Shelby Duis died on 1-4-2000. The autopsy report shows that there were several injuries. Some of the injuries occurred to Shelby in the last 24 hours of her life and other injuries were older in nature. Dr. [REDACTED], who did the autopsy, as well as Dr. [REDACTED] that reviewed the autopsy, state that a majority of these injuries were inflicted injuries. Both Dr. [REDACTED] and Dr. [REDACTED] ruled out accidental explanation for a majority of the old and new injuries that Shelby had.

FACTOR 4. Dr. [REDACTED] and Dr. [REDACTED] stated that the majority of the injuries found on Shelby at the time of the autopsy were inflicted injuries and, in no way, could be explained as being accidental. Dr. [REDACTED] and Dr. [REDACTED] found inflicted injuries, which would have occurred within the last 24 hours of Shelby's life. Dr. [REDACTED] and Dr. [REDACTED] also found older inflicted injuries on Shelby's body.

FACTOR 5. Based on the statements from Dr. [REDACTED] and Dr. [REDACTED], a majority of the injuries found on Shelby's body were inflicted and; therefore, resulted from the acts or omissions of the responsible caretakers. Jesse had caretaker responsibility for Shelby. Both Jesse and Heide lived in the family home together. Both Jesse and Heide are either responsible for causing the injuries themselves or they are responsible for not preventing one or the other from inflicting the injuries on Shelby Duis. During Shelby's last 24 hours of her life, the only two caretakers to have any contact with Shelby were Jesse Wendelsdorf and Heide Watkins. Dr. [REDACTED] and Dr. [REDACTED] state that there were a number of injuries that occurred within the last 24 hours of Shelby's life that could not be explained accidentally. These injuries were inflicted.

Shelby Duis is listed as the victim in this allegation. Jesse Wendelsdorf is listed as the person responsible for the abuse in this allegation.

This report of Sexual Abuse in the 2nd Degree is **CONFIRMED**. All of the following necessary factors have been met by the required preponderance of the evidence.

FACTOR 1. Shelby Duis is a child, [REDACTED].

FACTOR 2. Heide Watkins is Shelby's biological mother and is responsible for caretaker supervision of Shelby.

FACTOR 3. Dr. [REDACTED] has reviewed the autopsy reports and states that Shelby Duis was sexually assaulted within the last 24 hours of her life. Jesse and Heide were the only adults responsible for caretaker supervision of Shelby. Heide was either a participant in the sexual abuse or was aware of the fact that Shelby was being sexually abused and did not prevent the abuse.

FACTOR 4. Shelby Duis was under the age of twelve.

Shelby Duis is listed as the victim in this allegation. Heide Watkins is listed as the person responsible for the abuse in this allegation.

This report of Sexual Abuse in the 2nd Degree is **CONFIRMED**. All of the following necessary factors have been met by the required preponderance of the evidence.

FACTOR 1. Shelby Duis is a child, [REDACTED].

FACTOR 2. Jesse Wendelsdorf is Heide Watkins' paramour. Jesse Wendelsdorf lived in the family home and was, therefore, responsible for caretaker supervision of Shelby Duis.

FACTOR 3. Dr. [REDACTED] has reviewed the autopsy reports and states that Shelby Duis was sexually assaulted within the last 24 hours of her life. Jesse and Heide were the only adults responsible for caretaker supervision of Shelby. Jesse was either a participant in the sexual abuse or was aware of the fact that Shelby was being sexually abused and did not prevent the abuse.

FACTOR 4. Shelby Duis was under the age of twelve.

Shelby Duis is listed as the victim in this allegation. Jesse Wendelsdorf is listed as the person responsible for the abuse in this allegation.

RATIONALE FOR PLACEMENT OR NON-PLACEMENT ON REGISTRY:

This **CONFIRMED** report of Physical Abuse is placed on the Central Abuse Registry as a **FOUNDED** report. Registry placement is mandated for all confirmed reports of physical abuse that are not minor or are not isolated. The injuries inflicted on Shelby Duis were clearly not minor in that they resulted in her death. Autopsy reports show inflicted injuries of differing ages. Therefore they are not isolated.

This **CONFIRMED** report of Sexual Abuse is placed on the Central Abuse Registry as a **FOUNDED** report. Registry placement is mandated for all confirmed reports of Sexual Abuse that were committed by a person over the age of 14 years. Both Heide Watkins and Jesse Wendelsdorf are over the age of 14 years.

JUVENILE COURT INVOLVEMENT REQUESTED, INCLUDE DATE AND TYPE OF ACTION REQUESTED, IF ANY:
(If action is requested, state date and specific action requested.)

[REDACTED]

CRIMINAL COURT INVOLVEMENT REQUESTED, INCLUDE DATE AND WHO REFERRED TO IF ANY REQUESTED: (If action is requested, state date, time, and type of action requested.)

The Dickinson County Sheriff's Department, as well as the Spirit Lake Police Department, and the Iowa Division of Criminal Investigation are currently conducting an intensive investigation in to the death of Shelby Duis. Heide Watkins has been charged with first degree murder of her daughter, Shelby Duis. Jesse

Wendelsdorf has been charged with first degree murder as well as sexual abuse regarding the death of Shelby Duis.

(Rev 7/97)

Attachments (if any, list):

CHUCK ILLG, Child Protection Worker	02/04/2000
Phyllis Slawson	Date
PHYLLIS SLAWSON, Supervisor	02/04/2000
	Date

(Rev 7/97)

Iowa Department of Human Services
CHILD PROTECTIVE ASSESSMENT SUMMARY - Part B
Assessment of the Child and Family Functioning, and Development of Suggested Plan of Action

COMPLETE DATE: 02/04/2000		ADDENDUM DATE:	
INTAKE DATE: 01/04/2000	CHILD PROTECTION WORKER: PHYLLIS SLAWSON	INCIDENT: [REDACTED]	COUNTY: DICKINSON
HOUSEHOLD ADDRESS: 1501 JACKSON ST., SPIRIT LAKE, IA 51360			
DIRECTIONS TO HOME:			
TELEPHONES: (Household)		(Other)	
CURRENT LOCATION OF CHILD/SUBJECT:			

TYPE OF ASSESSMENT SUMMARY: Addendum to a previously completed written summary
HOUSEHOLD COMPOSITION: SEX (M) Male, (F) Female; RACE (A) African-American, (B) Bi-Racial, (C) Caucasian, (H) Hispanic, (N) Native American, (P) Pacific Islander/Asian, (I) Indo-Chinese, (O) Other, (U) Unknown; ROLE (V) Child Subject, (S) Sibling, (P) Parent, (F) Foster Parent, (R) Relative, (L) Paramour, (O) Other.

NAME	DOB	ROLE	SEX	RACE	SS#	FACS#	COMMENTS
WATKINS, HEIDE	[REDACTED]	P	F	C	[REDACTED]	[REDACTED]	
WENDELSDORF, JESSE	[REDACTED]	L	M	C	[REDACTED]	[REDACTED]	
DUIS, SHELBY	[REDACTED]	V	F	C	[REDACTED]	[REDACTED]	
MCKNIGHT, TYLER	[REDACTED]	S	M	C	[REDACTED]	[REDACTED]	

HISTORY OF SERVICES

Heide stated that the only type of therapy or counseling that the family has had is when she and her first husband divorced, [REDACTED]. Heide stated that she thinks it was offered through the Spirit Lake Elementary School. Heide denies that she has ever been involved with any alcohol or drug treatment classes.

Heide verbally agreed to work voluntarily with [REDACTED] Services on 10-22-99. However, Heide missed a lot of appointments in the process of getting this arranged with the SW II, Deb Nelson, and with the [REDACTED] worker, Heather Wright. The only [REDACTED] visit that occurred was on 12-23-99. Other attempts were made but Heide did not keep her appointments. The last attempt made by Heather was on 1-3-2000. Heather knocked on the door but there was no answer. Heide stated that she did not hear Heather knock on the door. Heide told Deb Nelson that she would call Heather at [REDACTED] where Heather was staying. Heather also reported on 12-29-99 that Heide did not answer the door at their scheduled appointment time. Heather stated that when she drove by the home later that same day, two men were seen entering the home.

The Department of Human Services found out on 1-4-2000 that Jesse Wendelsdorf, Heide's paramour, had been living in the family home for the past 3 to 6 months (specific time frame not established). Jesse has elected not to cooperate in the assessment.

PRESENTING PROBLEM

Both Heide and Jesse have elected not to participate in this assessment. The following information is from a previous assessment. Since that time both Heide and Jesse have been charged with first degree murder in the death of Shelby Duis, Heide's biological daughter. Jesse has also been charged with sexual abuse of Shelby Duis. This worker would also like to note that when the previous assessment was conducted, Heide denied that anyone else was living in the family home.

During the 1-4-2000 assessment, Heide stated that she has really been doing very well. Heide stated that she and the children are getting along good and, as a family, they really do not have any problems. Heide stated that she works for her stepfather and she is making a good wage. Heide stated that the children usually listen to her, although there are those times when [REDACTED]. Heide stated that her divorce was hard, at first, and it was hard on the whole family. Heide stated that right after the divorce, she and her ex-husband did not get along but they are getting along better now. Heide stated that her ex-husband has a new girlfriend who is really nice and really good to the children. Heide stated that it sounds weird but since her ex-husband has started dating his new girlfriend, they are actually able to get along better. Heide stated that she has even gone out with his new girlfriend. Heide stated that she gets [REDACTED]. Heide stated that she has no contact with Shelby's father and does not receive child support. Heide stated that Child Support Recovery is not able to locate Shelby's father. Heide stated that the family does not receive any assistance from the State of Iowa.

This worker would like to note that there have been concerns in the past about Heide's drug and alcohol use. During all of the previous assessments, Heide consistently stated that it was a problem in the past but was no longer a problem. However, drugs were found in the home at the time of Shelby's death.

ASSESSMENT OF THE CHILD AND FAMILY FUNCTIONING: (Describe each of the following, identifying strengths and needs.)

Home Environment:

Heide has been living in the same house since November of 1998. She rents this home from her parents. This worker would note that it is an older house, but it is very nicely decorated and very nicely kept. The home environment did not pose a danger to Heide's children.

Parent/Caretaker:

During previous assessments, Heide stated that she grew up in Spirit Lake, IA. Heide stated that she has five older brothers. Heide stated that her mother and father divorced when she was ten years old. Heide stated that she lived with her mother after the divorce. Heide stated that she and her mother have always been very close and have always gotten along really well together. Heide stated that she dropped out of high school in the eleventh grade. Heide stated that school was really hard for her and that is why she dropped out. Heide stated that if she would have stayed in school, she would have had to retake her freshman year of classes. Heide stated that she moved out of her mother's home two months before she turned eighteen years old. Heide stated that her brother was killed in a helicopter accident in Japan that summer and things were really hard that summer for both her and her mother. Heide stated that when all of that was going on, she decided to move out of the home. Heide stated that she married Troy McKnight in 1990. Heide stated that the two of them lived together a year before they were married. Heide stated that the divorce was finalized in 1998 though the two of them separated in 1994. Heide stated that she and Troy's marriage did not work because [REDACTED]. Heide stated that she and Kevin Duis, Shelby's father, started to live together in 1995. Heide stated that that relationship ended in early 1997 before Shelby was even born. Heide stated that that relationship did not work because Kevin was a creep. This worker would like to note that Kevin is now living with [REDACTED]. This worker has received information which states that Jesse Wendelsdorf used to live with [REDACTED]. Heide stated that Kevin has only seen Shelby twice and that was when she was a very young baby. Heide states that she

works for Moritz' Construction and she has worked there for the past five years. Heide stated she has a good boss because her stepfather owns the company. Heide stated that she enjoys riding bikes with her children and she enjoys going water skiing. Heide also stated that she has a friend that has a boat so she and the children enjoy boating in the summer together. Heide also states that she likes to take the children to the park so that they can play. Heide stated that her best qualities is that she is a hard worker and she is a good mother. Heide stated that she is really easy to get along with. When this worker asked Heide what she would change about herself. Heide stated that she might be a little too lenient when it comes to discipline. Heide stated that her job is very demanding and physically tiring. Heide stated that sometimes she is just too tired to deal with the children's behaviors.

Jesse Wendelsdorf has stated that he does not wish to participate in the assessment. Jesse is Heide's paramour and has been living in the family home.

Domestic Violence:

Heide has never said that there was ever any domestic violence in any of her relationships, although we have no current information regarding domestic violence between Heide and Jesse.

Substance Abuse:

Jesse admitted to law enforcement officers that he does smoke marijuana. Friends of Jesse and Heide state that they brought over to them a box which contained Methamphetamines and paraphernalia. Jesse and Heide wanted them to keep it for them. This took place after the death of Shelby.

Heide has admitted that there used to be a problem with drugs and alcohol but states that those issues are resolved. I continue to hear concerns.

Child(ren): (Include all children in home.)

Shelby Duis was found dead on 1-4-00 [REDACTED]

Shelby used to go to Small World Day Care. However, since 10-21-99, [REDACTED], cared for Shelby. Heide stated that Shelby is very active and is a smiley child. Heide stated that Shelby is always on the go and is always running through the house. Heide stated that Shelby will climb on anything she finds. Heide stated that Shelby is in good health and has never had any serious medical problems. This worker has noticed a big change in Shelby's vocabulary since the daycare change was made. Shelby still appears to be delayed with her speech but is starting to talk in sentences. This worker never observed any immediate behavior concerns. On 12-3-99, Shelby sat on her mother's lap and Heide was poking her in the stomach. Shelby was laughing. Shelby later sat on the counter while her mother made her something to eat. Both Heide and [REDACTED] stated to this worker that they felt Shelby was pale and maybe anemic. Both reported that Shelby bruised easy. This worker would like to note that Dr. [REDACTED] saw Shelby on 1-3-2000, and scheduled a follow up appointment for 1-4-2000, to run some blood work to follow up on those concerns. This worker learned from Dr. [REDACTED] that he did treat Shelby for a rash/lesion problem on her inner thigh about six months ago with medication and the treatment was successful. Small World staff stated that they felt there was a change in Shelby's behavior over the past several months before she quit coming to their facility. They reported that Shelby seemed to become more withdrawn and angry. Small World also

stated to this worker that Shelby was uncoordinated and would fall face down while running across the floor.

[REDACTED]

Social/Environment:

This worker has no information regarding Jesse's support system due to the fact that Jesse chose not to participate in this assessment. The following is from a previous assessment.

Heide stated that the family does not belong to any groups, organizations, or church. [REDACTED] Heide has stated in the past that she could always count on her mother and stepfather to help her out if things get tough. Heide consistently stated that she and her mother have always been very close and have always had a very good relationship. Heide also stated that she is close to her biological father who lives in Spirit Lake, IA. Heide stated last year that one of her closest friends was [REDACTED] and that she could always count on [REDACTED] to help her out. [REDACTED] Heide went to work early in the morning so her mother would come over and get Tyler and Shelby up and ready for the day. Heide stated that her mother then took Tyler to school and Shelby to her home.

Analysis of Family Functioning:

[REDACTED] Heide, and her paramour, Jesse have been charged with first degree murder of his sister, Shelby Duis. Jesse has also been charged with sexual abuse of Shelby. It appears that there is a significant amount of information about family functioning that Heide has not disclosed to our agency.

SUGGESTED PLAN OF ACTION: (Provide rationale for any of the following suggested plans of action recommended, indicate with a N/A if the section is not applicable.)

Identification/Development of Informal Supports for Child and/or Family (if any):

Currently, both Jesse and Heide are in jail waiting trial. This worker has no specific recommendations for informal supports. [REDACTED]

[REDACTED]

Identification/Development of Services Provided by Community Agencies or Organizations (if any):

[REDACTED]

Department Services Provided and Recommendations (if any):

[REDACTED]

PHYLLIS SLAWSON, Child Protection Worker
Paula Heckenlively

PAULA HECKENLIVELY, Supervisor

02/04/2000

Date
02/04/2000

Date

(Rev 7/97)

Replies



THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

December 12, 2000

William P. Angrick II
Citizens' Aide / Ombudsman
215 East 7th Street
Des Moines, IA 50319-0231

Dear Mr. Angrick:

The death of Shelby Duis was a tragedy, one that has touched us all.

Shelby's death demands that we take a hard look at our performance, our policies and our system design. 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.

Iowans care deeply about the safety of our children. Our staff is highly dedicated to their work, as are all of those who join with us to protect children, such as teachers, physicians, child-care workers, neighbors, law enforcement, and county attorneys. But we need more than caring and dedication. We all need to know what to do, when to do it, how to do it together, and we all need the resources to do it well.

We are concerned that the Ombudsman "found a number of instances when DHS staff did not respond appropriately or could have responded differently to concerns raised about Shelby." We are committed to taking action to improve. As pointed out in the report, "the Ombudsman found many actions or decisions by DHS workers to be appropriate. There were also some actions or decisions about which the Ombudsman could not make any findings or reach any conclusions, given the evidence that was obtained or was available."

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. We believe the greatest value in the Ombudsman's report is in the ideas offered to strengthen all parts of the system for protecting children. It is critical to now engage our collective will to address key areas for improvement. Therefore, the focus of our response will be on the recommendations made by the Ombudsman.

For purposes of our comments we have grouped the Ombudsman's recommendations into 5 broad areas; Intake, Policy, Training, Monitoring and Improving Performance, and Expertise. Our response will focus on actions already taken, those in progress, and work still to be completed.

Intake

Recommendations 1,6, 9, 10, 11, 12,13, 14

The Ombudsman's report makes several recommendations to improve the quality and consistency of intake decisions. We agree that an intake system should make it clear and simple to report alleged child abuse, facilitate the complete and accurate transfer of information from the intake worker to the person completing the assessment, and should result in the right decisions at the right time.

Action

We strongly concur that the intake system must be strengthened, and we have already made several improvements to our intake system.

- Since April 1, 2000 we have mandated the entry of all rejected intakes into our management information system. This ensures supervisory review and allows us to monitor for potential policy and practice improvements.
- Since August 2000, all reports received after hours by the Hotline are now also faxed to the appropriate county office the following morning in addition to immediately paging the on-call worker.
- We have completed two training sessions focused on collecting and documenting information received during an intake.
- A third training focused on making the right decision on whether to accept or reject a report of alleged child abuse is scheduled for February 2001.
- We revised our written notice to reporters in September 2000 to include a clear reason if a report is rejected and a contact person for follow up if a reporter disagrees with the decision not to assess the report.

We have begun action to clarify several intake policies that will be published in our employee manual in January 2001.

- These clarifications focus on improving intake documentation and stating when and under what conditions an intake worker is expected to re-contact a reporter of child abuse.
- We are also clarifying that a supervisor will review all written reports of alleged child abuse received from a mandatory reporter to determine if it provides additional information from their original oral report, and if a rejection decision should be reconsidered.

Future Action

The Ombudsman recommends we consider centralized intake as a strategy for improving the intake system. While we strongly concur with the results the Ombudsman believes will be accomplished through centralized intake, (i.e. easy access and consistent and accurate decision making), there may be other effective strategies to consider. Since centralized intake would be a significant change in how Iowa's intake system works today, we will establish a thoughtful deliberative process to review this issue in consultation with community stakeholders and policy makers.

Policy

Recommendations 2, 5, 16, 18, 19, 20

The Ombudsman makes a series of recommendations that focus on improvements and clarifications to the procedural requirements for DHS staff who perform child abuse assessments. As indicated in the following comments, we have begun action to implement many of these changes.

Action

In January 2001 the DHS employee manual will be updated to include the following policy clarifications:

- Revision of the definition of who is a child abuse "reporter", to include an individual who has been identified by a reporter (i.e. person calling DHS) as the source of the allegation
- Expectation that in those instances when a Child Protective Worker (CPW) refers a child for examination by a physician, the CPW will be expected to contact the physician before the scheduled exam

- Clarification on when home visits are required and whether or not they should be announced or unannounced

In Process

- We have begun a process to review and create a best practice method for the transfer of cases from the CPW to the ongoing Service worker to avoid potential problems. Once this model is established, policy clarification and training will occur.
- We also agree that a Legislative review of the 20-business day time frame for completing assessments is necessary, and we will support extensions in limited circumstances.

As suggested by the Ombudsman, we have reviewed the 48-hour time frame for the filing of written reports by mandatory reporters. At this time, we do not believe an extension will increase reporters' compliance, and we are concerned that enforcement is likely to discourage reporting which would be counterproductive to the goal of enhanced reporting to assure child safety. Therefore, we recommend the time frame should not be extended, nor should enforcement be enacted.

Training

Recommendations 3, 4, 7, 15, 17

The Ombudsman makes several recommendations for improving the training for mandatory reporters and department staff. In addition, there are recommendations regarding the basic tools, such as cameras, bruise charts, injury measurement instruments, etc., needed for staff in order to do a complete and thorough assessment.

Action

Mandatory Reporter Training

- In April 2000, we provided information to mandatory reporters statewide regarding their duties as mandatory reporters and directing them to training resources and training opportunities.
- Although current Iowa statute places the primary responsibility for mandatory training with the employer, the Council on Human Services Fiscal Year 2002 budget request includes funds for us to assist in the development and provision of mandatory reporter training. Clearly, training needs to be more frequent and interactive, and regular communication with mandatory reporters needs to occur.

DHS Training

- Over the last year, we have redesigned our training curriculum for child protective workers to improve the focus on the skills our staff needs to do this work.
- The training curriculum is being reviewed in light of the Ombudsman's recommendations.
- We are also currently working with the Department of Public Health to improve training provided to staff on substance abuse and its impact on families and child safety. We have conducted a joint training with Department of Public Health staff and substance abuse treatment providers, and we are currently working to develop a substance abuse screening tool.

In Process

- By February 2001, we will assure all child protective staff have the necessary tools, such as cameras, bruise charts, injury measurement instruments, etc., to gather information and document evidence of abuse.

Monitoring and Improving Performance

Recommendations 8, 21

The Ombudsman recommends improvements in reviewing and monitoring completed intakes and assessments. He further recommends that we evaluate whether we have the staffing resources necessary to provide adequate review, oversight and consultation.

Action

- 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.
- We strongly believe that consultation provided by line supervisors is critical for effective child protection. Today, we do not have enough supervisors to meet this challenge. As part of a three-year plan to meet national standards, the Council on Human Services Fiscal Year 2002 budget request also included funds for additional supervisors. This will improve the access of child protection workers and child welfare workers to face-to-face supervision, case consultation, and on-the-job training.

Expertise

Recommendations 22, 23

The Ombudsman recommends we review the functioning of multidisciplinary teams and that we work with others to improve the availability of medical child abuse expertise. Medical expertise for the recognition and verification of abuse is critical to the assessment of abuse and the actions taken when abuse is confirmed.

In Process

- We recognize the value and use of multidisciplinary views when making decisions regarding child abuse cases to insure that decisions are not made in isolation or without important expertise. We also recognize that such expertise and consultation is not always readily available to our staff. We will bring representatives of current multidisciplinary teams and other interested parties together to define how best to meet this need.
- We are also working with the Department of Public Health, the University of Iowa Hospitals and Clinics, and the Iowa Chapter of the Academy of Pediatrics to improve the accessibility to medical child abuse expertise.

The Ombudsman's extensive review of this case and his subsequent recommendations have provided an opportunity for all of us to focus on the critical issues facing the child protection system in Iowa. We are firmly committed to learning from this review and we have already completed or initiated action on many of the recommendations in this report and we have plans for acting on the others. We take seriously our significant role in the protection of children and we will aggressively pursue whatever changes it will take to be successful in ensuring the safety of Iowa's children.

Sincerely,



Jessie K. Rasmussen
Director

December 12, 2000

Mr. William P. Angrick, II
Citizen's Aide-Ombudsman
Capitol Complex
215 E. 7th St.
Des Moines, Iowa 50319-0231

Dear Mr. Angrick:

I am thankful to have an opportunity to respond to the Ombudsman report. I have read this report carefully, just as the public will when the Ombudsman report is released to the public. This report is detailed and the Ombudsman obviously spent a lot of time preparing the report. I was sorry to see that while the Ombudsman pointed out that there were actions and decisions that were appropriate, they do not show up in the report. In the next few pages, I will address some assumptions, conclusions, and testimony that I disagree with in the Ombudsman report. However, I would first like to point out that there are things that I agree with in the Ombudsman report. With the benefit of 20/20 hindsight, the Ombudsman has been able to take sworn testimony from 46 persons who have knowledge of this case. Some of the 46 persons are experts or attorneys who had the ability to take sworn testimony of numerous individuals; some of which are experts in the medical field. The Ombudsman spent approximately ten months in reviewing the Department's, and more specifically, my handling of the case. The Department and, more specifically myself, did not have the benefit of ten months to conduct an investigation. Nor did the Department or I have the ability to base a finding after two separate murder trials. Finally, the Department and I did not have the cooperation of persons in the community who had knowledge or suspicions of abuse perpetrated toward Shelby.

Medical professionals were used to assist me in determining whether or not injuries were inflicted intentionally or if the injuries were accidental. I have great respect for the doctors I used in my assessments on the Watkins family. I feel both Dr. Taylor and Dr. Kalkhoff are competent, hard-working individuals, who take great pride in their profession. In no way would Dr. Taylor or Dr. Kalkhoff knowingly leave a child in a dangerous situation. That goes against everything these men stand for.

However, in reading the Ombudsman report, you will find that other medical experts are not in agreement with Dr. Taylor and Dr. Kalkhoff's diagnoses. In fact, you will find that two of the medical experts are not in agreement with each other.

A third expert, who was used by the State in the prosecution of Jesse W. and Heidi W. states that Dr. Kalkhoff's diagnosis on 1-3-00 of Shelby is medically sound and accurate. If the medical community cannot agree on the medical evidence, that obviously is a concern. That does not mean one is more competent and one is less competent. What it does point out is that I did seek medical advice and was given a medical opinion.

I do not have a background in medical sciences and, therefore, I must trust the medical opinions of the doctors I have access to. I attended a medical staffing at Sioux Valley Hospital after Shelby's death. In attendance at that staffing, among others, was Edward Bjornstad, County Attorney; Dan Thomson, Spirit Lake Chief of Police; and Doug Ricke, Police Officer from Spirit Lake. At that staffing, we learned of the horrible abuse suffered by Shelby the last months of her life. The injuries were extensive and brutal. The first thing that crossed my mind is "how could Shelby have received all of these sickening injuries and we not receive a single call regarding them?" I could not understand how that could be possible. In fact, I personally asked Dr. Kaplin, a child abuse expert from Sioux Falls, South Dakota, who testified for the

prosecution, about the phone calls I received from Sherry Dawson about a bad rash in the vaginal area, as well as the discolored eyes and bruise to Shelby's forehead. Dr. Kaplin stated to the room of professionals that Shelby was sexually abused and that the sexual abuse took place within a few hours of Shelby's death on 1-04-00. This is consistent with Dr. Kalkhoff's finding on 01-03-00 when he examined Shelby and scheduled an appointment for the following day, 01-04-00 to do some blood work. Dr. Kalkhoff, at this 1-03-00 office visit, after a complete and thorough physical examination, found no evidence of sexual or other abuse.

Dr. Kalkhoff also stated to me that of all the injuries discovered at the time of Shelby's autopsy, the only injury that could be explained as accidental was the injury to Shelby's forehead. On a later date, Dr. Kaplin stated that Dr. Kalkhoff's diagnosis of the injury to Shelby's forehead, after his complete and thorough examination, is accurate. Dr. Kaplin even suggested to this worker that he would be traveling through Iowa and he would make a point to stop in Spirit Lake and speak to the Ombudsman. It was also at this meeting that Dr. Duffek stated that the injury to Shelby's fractured metacarpal occurred 10 to 20 days prior to 10-21-99. The department never received a call about this injury prior to that date. I question how such an injury could have gone unnoticed by the same workers at Small World Day Care who reported the injury on 10-21-99.

In retrospect, the explanation for the injury given by Heidi was, in fact, a lie. However, as stated before, I have no medical training or medical background in radiology. Dr. Shah suggested that would require a medical professional to tell what causes that type of injury. It is entirely possible that Shelby fell out of her crib and re-injured her hand. I would agree with Dr. Shah, except that the injury occurred 10-20 days prior. That information would have immediately shown that Heidi was lying about the injury and there would have been no debate on whether it could or could not have been caused by falling out of a crib.

Not having an accurate date of the injury crippled my ability to come to an accurate finding as to whether the injury was accidental or non-accidental. Still, I do not understand how this injury went undetected by the licensed daycare provider (though only a provisional license due to non-compliance with state law and state policy), for 10-20 days.

When Dr. Shah was told about Dr. Duffek's testimony at the criminal trials, she then changed her opinion to "then she believes the area of the fracture was re-injured." Dr. Shah also stated (p. 87) "but every time she moves her hand, then that will be much more severe pain." The Ombudsman report relies heavily on Dr. Shah's testimony. Given her testimony about the severe pain, I am befuddled as to how the staff at Small World Day Care did not notice the 10-20 day old broken hand.

In regard to other injuries seen on this date, Dr. Taylor also viewed them. I have no comment on the differences of opinion between Dr. Taylor and Dr. Shah. Dr. Shah also states that the injury to Shelby's face, which was photographed on 2-23-99, is clearly a slap mark. Dr. Shah states that she would expect an experienced worker to find linear bruises suspicious. Dr. Shah states that she feels the injury is indicative of a slap to the face.

Edward Bjornstad told Attorney Bradley Howe and me that a forensic pathologist and a pediatrician looked at all of the photos, including the photos taken on 2-23-99. Bjornstad stated that neither the forensic pathologist nor the pediatrician stated to them that the injury was inflicted or that it was a slap mark. Again, I cannot explain the differences in the medical professionals' opinions.

I also understand the Ombudsman's, Dr. Taylor's, and Dr. Kalkhoff's concern about not being notified by me of my concerns prior to Shelby being seen. That is a practice I have since changed. I agree that placing

a call to the physician, IF THEY ARE AVAILABLE (which is not always the case), would be the best practice. In the past I have not always placed a call beforehand, especially in a difficult case, because I did not want to bias the examination. Dr. Taylor especially was concerned about not being informed of the concerns regarding Shelby before he conducted his investigation. I have worked with Dr. Taylor since the death of Shelby, and I would now notify physicians of concerns prior to the child being seen. The only thing I would like to point out is that when Dr. Taylor and I spoke about Shelby's injuries and Heidi's explanations, Shelby was still in the hospital. Dr. Taylor and I discussed all of the concerns and Dr. Taylor knew that there was a concern of abuse. If Dr. Taylor feels that additional information would have changed his examination and treatment on 10-21-99, it certainly could have resulted in another examination or a second medical opinion on 10-22-99. The information I shared with Dr. Taylor on 10-22-99 was the information I had just received from Heidi and [REDACTED]. The bottom line is that Shelby was a patient at the Dickinson County Memorial Hospital when Dr. Taylor and I discussed the facts of the case. Though Dr. Taylor did not have the information on 10-21-99, he did have the case information on 10-22-99 while Shelby, Heidi, [REDACTED], and I were at the hospital waiting for his dismissal of Shelby.

In short, Shelby's treating physicians did thorough examinations of Shelby and FOUND NO EVIDENCE OF ABUSE. Shelby's last doctor appointment was the evening prior to her death.

The Department has only 20 working days to complete a report of suspected abuse. I did not have the advantage that the Ombudsman had in reference to reviewing the case information after all the facts were known. In essence, I was not able to turn to the last page and find out how the story ends. I wonder how the individuals who completed the Ombudsman report would feel if they had their past work examined for ten months? One of the members worked for the Department of Human Services. I wonder if there would be anything she would have done differently if she could go back and look at some of the families she worked with. One of them worked in the Story County Attorney's Office. I wonder if she ever had a case where, in hindsight, she would have asked for a tougher sentence. Possibly there was a case where she did the best she could with the information she had only to find out that there was additional information that had not yet come to light.

Unlike the Ombudsman, I did not have the ability to put off the assessment until after two criminal trials where expert testimony was presented. In Jessie W. and Heidi W.'s trials, the public learned of extensive drug use by both of the defendants. I asked the very same questions of Heidi. Heidi denied any drug use. The Ombudsman, in my opinion, suggests that I somehow had the ability to prove that Heidi was using drugs. The significant term is "prove". I did have a suspicion of drug use. That is why it is noted in each report. What the public may not realize is that in cases prior to and after Shelby's death, I have requested the removal of children when drug use has been proven. However, this does not always result in the removal of the children from the family home. Again, this is no way suggests I am questioning the competency of the State's Juvenile Referees. I am suggesting quite the opposite. Juvenile Referees are to follow Iowa law. Even when it is proven that the parent or caretaker is a methamphetamine user, it must still be proven that the children are in imminent danger, by clear and convincing evidence. This is a very high standard of proof. It is my belief in working with the Juvenile Court system that County Attorneys, Juvenile Referees, and Associate District Judges alike, would like more precise guidelines set forth by the Iowa Legislature.

The State of Iowa has identified that there is an alarming methamphetamine use problem and methamphetamine manufacturing problem in the State of Iowa. However, Iowa laws have not addressed this concern in Juvenile Court. The Ombudsman suggests that because I did not take action on a suspicion of drug use, I was negligent in my duties as a CPW. I want to point out that not only does the Court not always have the ability to remove children on a suspicion of drug use, there are cases where the Court does not have the ability to remove children when methamphetamine use by the parent/caretaker is PROVEN.

In this case, Heidi was charged with two counts of a controlled substance, namely methamphetamine and marijuana. Heidi was also charged with one count of Child Endangerment. However, no call or report was made to the Department of Human Services. The Department's knowledge of those charges not only may have, but would have changed the way the Department and Juvenile Court proceeded with the case. The question should be asked "How can someone be charged with possession of drugs (methamphetamine and marijuana), and charged with child endangerment without a referral of suspected abuse being made to the Department of Human Services?" Likewise, would not the above mentioned charges suggest that at least [REDACTED] and Shelby Duis were Children in Need of Assistance (CINA)? A CINA finding would have involved Juvenile Court. Finally, on 10-22-99, Heidi agreed to random drug testing. That is currently the only way possible I know of to prove or rule out drug use. That recommendation was made as it is stated in my report, but when the case was reassigned, it was never followed up with.

In fact, I have talked with Edward Bjornstad, the Dickinson County Attorney who knows this case better than any other. He stated to attorney Bradley Howe and me that had I gone to him as the County Attorney after any of my investigations on the Watkins family, it would have been very difficult to remove Shelby because there was no medical evidence of abuse. It is Bjornstad's belief that we would "have been bounced out of Court".

I simply would like to point out that after Shelby's death, persons who had knowledge of Shelby and concerns about her care came forward and cooperated with the criminal prosecutions, Ombudsman report, and the internal review conducted by the Department of Human Services. I have heard some of the criminal trial testimony; I cooperated in the internal review and the Ombudsman report. I am torn as to how to respond to the testimony in the Ombudsman report from individuals such as Gosch, Phelps, Linn, Roseberry, Dawson, and Dressel. I do not want to go through the Ombudsman report and respond to every line or statement that I am not in agreement with. I do not see how a prolonged "he said, she said" banter helps change policy or helps re-write child protection laws. It has been suggested to me that by not responding to some of the statements which I feel are inaccurate, I will only look guilty in the eyes of the public. I realize that with the vast publicity of this case, some have already concluded that I did not do my job and that I am responsible for Shelby's death. This is obvious in the many phone calls that my wife and I received in the middle of the night wishing ill will to my wife, my four children, and me. I know I cannot sway the public opinion of me. I am not responding to the Ombudsman report to do that. I am responding to the Ombudsman to try to point out that things do not always appear as they are. I hope that changes can be made within the system. It would be nice if we had some of the power that the Ombudsman's office has. They have subpoena power and can conduct all of their interviews in a controlled environment. The Ombudsman's office can document interviews verbatim. Law enforcement conduct interviews in their offices because it is very important to be able to control the environment. CPWs do not have the ability to subpoena subjects of a report or collateral witnesses. In fact, if the parents refuse to cooperate in the investigation, there is little we can do. We can seek a court order to force them to cooperate, but that can take time. If we request to remove the children because of this, we still have to prove imminent danger by clear and convincing evidence. CPWs cannot even force the parents to allow us to meet with the children privately.

However, this does not change the fact that I disagree with some of the conclusions and assumptions the Ombudsman make in the report. Brad Howe and I spoke with Edward Bjornstad about why Roseberry, Dawson, and Dressel were not called as witnesses by the prosecution. Bjornstad made it very clear that Charles Thoman, a highly regarded, experienced prosecutor from the Iowa Attorney General's office, and he had spent hours upon hours going over the list of witnesses. Bjornstad stated that there was no doubt that there were credibility and motivational concerns about the names mentioned above. I only point this out because the Ombudsman puts heavy weight on their testimony. Bjornstad stated that he and Charles Thoman, the highly regarded prosecutor with the Iowa Attorney General's office, picked the best, most

credible witnesses to testify in the prosecution of Jesse Wendelsdorf and Heidi Watkins. Bjornstad stated that for specific reasons, Roseberry, Dawson and Dressel were not called to testify.

After Shelby's death, many individuals came forward with new information. One of the obstacles I faced in trying to get that information is that reporters often give bits and pieces of information because they do not want to get involved or they do not want to be identified as the reporter. I certainly understand those concerns. I do a majority of the mandatory reporter training in this area. I do the training for the local hospitals, schools, AEA, and over ICNs for various groups. I always make it a point to talk about and answer questions about that very issue. In fact, that is one of the reasons why the times do not match the actual time frames regarding the October 21, 1999, report. I did not want to disclose the reporter of abuse. In other words, if Heidi drops Shelby off at Small World at around 7:00 a.m. and my report has an intake time at 7:32 a.m., would there be any question as to who the reporter of abuse was?

Understanding that "not wanting to get involved" and "I am concerned that they will find out I turned them in" are very legitimate concerns; however, it must be weighed against what is best for the child.

I do feel that it is unfair for the Ombudsman to suggest that the statements they took, after the outcome was known, were the same information given to me at the time the referrals were made. I want to make that clear. I asked each and every caller specific questions that were paramount in my being able to do my job.

With regard to the "hotline" call made by Dawson, I unequivocally state that I NEVER received the information on the "hotline" intake sheet.

The best example of how memories have changed since Shelby's death is in the statement that I allegedly told three different people that I knew how to do my job better than they did. I did say that to Dawson. I told her that I knew how to do my job better than she did just like she knew how to do her job better than I would. I only made that statement because Dawson wanted me to just remove Shelby from the home. I tried to explain that I could not do that because the laws do not allow it. When Dawson questioned whether or not that was true, I used that statement.

Dawson, in reporting concerns, would not give me her last name. Dawson would not give me information about how she knew Shelby, Heidi, or who the boyfriend was. Dawson would not give me the name of the person who had information about possible drug use in the home. Dawson even tells the Internal Review conducted by the State of Iowa different information than she gives the Ombudsman. Dawson never reported to me that Jesse Wendelsdorf was the boyfriend. Dawson never reported that Jesse had another child by another party.

The State of Iowa has conducted an Internal Review of DHS practices in this case. Therein, it was reflected that Dawson stated that I was not aware of Jesse Wendelsdorf being in the Duis/Watkins home and that Wendelsdorf had been there for about one year. There are further statements contained in the Review that Dawson knew that Wendelsdorf was abusing Shelby. There was a statement that Dawson felt that the month of November was the worst month for abuse. I wish to stress that Dawson never made any reports to me in November. Dawson also reports that in December of 1999 she found Shelby lying motionless and noted many injuries to her body, including bruising to her vaginal area, head and scratches to her arms. Dawson told the Internal Review that she reported this information to an officer who asked why this information was not reported at the time she witnessed it. Dawson stated the officer told her that the information would have forced an investigation. I never received this information from Law Enforcement, nor did I receive the detailed information from Dawson. Had Dawson reported abuse every time she suspected it, especially in November, maybe the State would have had enough information to ask the Court to intervene. Maybe then there would not have been a concern about being "bounced out of Court."

In hindsight, which is what the Ombudsman used to question my work, Dawson could have shared all of the information she had and shared it in detail. I told Dawson personally if she felt that I was not handling her information the way she wanted it handled, she should call my supervisor. To me that was the responsible action to take. I know that Dawson cared dearly for Shelby. I do not doubt that for one minute. However, it appears that she possibly had more information, vital information, than she shared with me.

Roseberry also was very concerned about Shelby. However, Karen's stories and statements have changed after Shelby's death. I did speak with Karen on 10-21-99. I spoke with her at 7:32 a.m. Karen even states in the Internal Review that she spoke with me, but then changes her story to the Ombudsman. Karen also states in the Internal Review that she thought someone reported the bloody diaper to Chuck. This was never reported to me. Testimony of other workers at Small World supports this. This is, again, an example of how Karen's memory has changed since Shelby's death. Karen is the person who recanted the allegation of abuse as a mandatory reporter on 9-30-99 regarding Shelby.

Regarding the concern that I ignored a call reporting [REDACTED] and Shelby being left home alone, I can only say that I would not ignore a call saying that two young children were found home alone by themselves. What I was told is that there was a SUSPICION they were being left alone, but no actual proof. The law is pretty clear that we must have more than someone saying that they are SUSPICIOUS of neglect. I understand that we are now working under a new phrase, "when in doubt, work to take the child out"; however, that was not the catch phrase in 1999. Again, as I stated before, it amazes me how much information people had about Shelby after Shelby's death. There are many instances in the Ombudsman report that I disagree with regarding their conclusions and assumptions. By simply comparing the Internal Review with the Ombudsman report, there are differences of testimony from some of the before-mentioned.

When I read the Ombudsman report, a lot of faces popped into my head. The first faces I saw were that of my family, my parents, and my many relatives. I also saw the faces of high school classmates, friends from college, and the good people my hometown, Fonda, Iowa. I also saw the supportive faces of the members of Sacred Heart Parish in Spencer. All of them have helped my wife and me through the challenges of the past year. However, I think the one face that I see on almost a daily basis, that people do not realize, is that of Shelby. I was devastated by her loss. There has not been a day gone by that I have not thought of Shelby. Not one. I have questioned her death to the point where I have questions to my questions. I am in support of not letting her memory fade. I think Shelby's death has touched all of us in different ways. Shelby's death has made me look at who I am. It has made me question the status quo. It has made my strong religious faith even stronger.

I understand that some in the public will look at me as a "lazy state worker". I cannot change that. Some in the public will look at me as the person that let Shelby slip through the cracks. I cannot change that. Some in the public have a negative mental image of who I am and what kind of person I am. I cannot change that. In my life, no one has been harder on me than I have. Those who know me and work with me know that. I will work hard to change the things I can change. I have never striven to be mediocre or second best.

Since Shelby's death on 1-4-00, I have completed 142 investigations regarding children and dependent adults who allegedly have been abused. I have helped most of these children and dependent adults. The reality is, however, that some of these children and dependent adults were not helped. That is a horrible, devastating, hopeless thought to go home to every night.

I would like to thank the many people who called my wife and me and offered support. I want to thank the many people who wrote letters of support. I also want to thank the people who have offered Amy and me their support personally.

I would like to thank all of the professionals that have offered their support; some I work with on a daily or weekly basis; some I have not worked with in years. While the public may never know who you are and the support you offered, I know. I know what all of you have meant to me.

Finally, the public needs to be aware that I carry the heaviest case load of all DHS CPWs in this 22 county region. I have put in some 402 hours of overtime since January, 2000, and have completed 142 investigations since Shelby's death. If I were not a competent case worker, then I ask, why am I still receiving this heavy case load?

Yours truly,

A handwritten signature in cursive script that reads "Charles G. Illg".

Charles G. Illg