



PRESS RELEASE

State of Iowa Office of Ombudsman

Office of Ombudsman
Ola Babcock Miller Building
1112 East Grand Avenue
Des Moines, IA 50319-0231

Date: February 17, 2020

Re: Investigation into the Death of Natalie Finn

For more information contact:

Kristie Hirschman, (515) 281-3592 or (888) 426-6283 (toll free)

DES MOINES – Another tragedy like the death of teenager Natalie Finn could happen unless Iowa’s child-protection workers are given the resources and support they need, the State Ombudsman announced today.

That is one of the conclusions in a 160-page report released today by Ombudsman Kristie Hirschman. The report details her office’s investigation into how the Department of Human Services (DHS) handled child-abuse reports about Natalie Finn and her siblings. The 16-year-old girl was emaciated when emergency responders were called to her adoptive family’s West Des Moines home in October 2016. She died a few hours later at a local hospital.

The Ombudsman found that 14 child abuse reports had been made to DHS on behalf of the Finn children. The first three were made between 2005 and 2009. DHS’s records for those three reports were scant or non-existent, due to the agency’s policies for maintaining child-abuse records. The lack of any meaningful records prevented the Ombudsman from reaching conclusions on the appropriateness of DHS’s responses to those three abuse reports. Hirschman’s report criticizes those record-retention policies, stating that they hinder DHS workers’ ability to identify patterns of abuse.

Much of the Ombudsman’s report focuses on DHS’s responses to five child abuse reports made from November 2015 to May 2016. Of those five abuse reports, the first four were rejected by DHS intake staff – meaning those reports were not assigned to field staff for investigation. The Ombudsman concluded that three of those abuse reports should have been accepted for investigation. Included were two abuse reports, made six months apart, from school officials who described Natalie as “starving” and “very thin.” Intake staff did not document those descriptions and both abuse reports were rejected.

In reviewing policies in other states, the Ombudsman found that intake workers in Tennessee are required to read their written narrative back to anyone who makes a child abuse report by telephone. Had such a policy been in effect at DHS’s child abuse intake unit in 2015-2016, Hirschman’s report says, “it may have allowed reporters in the Finn case to point out significant errors and omissions, and may have resulted in several intakes being accepted instead of being rejected.”

The common concern among the five people who made child-abuse reports from November 2015 to May 2016 was that Natalie was not getting enough food at home. But no pattern was noticed until the fifth report, when a DHS worker took a step others did not and reviewed the four prior abuse reports about the Finn family. DHS intake workers are trained to check relevant histories for all abuse reports.

The May 31, 2016, abuse report was also the only one of the five that was accepted for investigation. The Ombudsman found a number of serious missteps with how that investigation was handled by field staff: key witnesses were never identified or interviewed; the case was plagued by procedural irregularities; and the case was allowed to languish for extensive periods of time.

According to the Ombudsman's report, child-abuse call volumes and accepted intakes have increased significantly since Natalie's death. This has resulted in a 36 percent increase to field workers' average caseloads from 2016 to 2018. Fortunately, additional funding for field staff was approved in 2019.

The Ombudsman found that the increased call volume is also straining DHS's centralized child abuse intake unit, where the number of intake workers has not increased since 2011.

"Although DHS received funding for the current fiscal year to hire additional field staff, I believe employees remain overworked, especially those in the intake unit," Hirschman said in the report. "I am seriously concerned that the recent budget increase is insufficient, especially in light of the increasing numbers of abuse reports and investigations since Natalie's death."

Hirschman made 14 recommendations to DHS. Included are recommendations that the agency:

- Conduct a systemic review of the agency's child abuse intake unit operations in light of the Ombudsman's findings.
- Modify its administrative rules to increase the retention period for child abuse intakes and assessments.
- Develop a policy for all intakes received by phone requiring intake workers to read their written narrative of the reporter's statements back to the caller before the conclusion of the call.
- Provide training and written guidance on legal tools available to field workers when faced with resistance from parents.
- Provide training and resources for intake and field staff impacted by secondary trauma, decision fatigue, and other job-related stress.

Hirschman also asks the Iowa Legislature to re-evaluate its expectations for the Child Fatality Review Committee and other oversight bodies responsible for reviewing child deaths. The Ombudsman found that the Committee has never convened since it was established in 2000 following the death of 2-year-old Shelby Duis.

According to the report, DHS implemented some systemic changes during the Ombudsman's investigation. In response to the report, DHS officials accepted 11 of the Ombudsman's 14 recommendations. "This was a tragic case," DHS Director Kelly Garcia wrote. "The Finn children should never have had to endure the treatment they received."

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

The Ombudsman will continue to monitor and pursue DHS's implementation of her 14 recommendations. The Ombudsman's full report can be viewed at <https://www.legis.iowa.gov/Ombudsman/>