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

PRESS RELEASE

State of Iowa
Office of Ombudsman

Date: September 8, 2020

Re: An Investigation of the Death of Sabrina Ray

For more information contact: Kristie Hirschman at (515) 281-3592 or (888) 426-6283 (toll free)

DES MOINES – The horrific abuse and starvation of a 16-year-old girl in 2017 might have been prevented if workers and contractors for the Iowa Department of Human Services (DHS) had been more diligent and communicated better with one another, the State Ombudsman concluded in a report released Tuesday.

The report, titled "Misplaced Trust: An Investigation of the Death of Sabrina Ray," disclosed that DHS had received 11 child abuse reports against the teenager's adoptive parents, Marc and Misty Ray, between 2010 and 2015. The Perry couple parented foster kids, adopted four children, and ran an in-home daycare. Several of the allegations lodged against the Rays reported that Sabrina looked extremely thin and unhealthy. Other reports accused the Rays of forcing their foster children to drink soapy water, stand over cold vents, and even eat their own vomit. It was also alleged that the Rays and others living in the home beat and belittled their adopted children and foster children.

None of the 11 abuse reports was founded by DHS staff. The Ombudsman, in its scrutiny of DHS files and interviews with staff, found that many of the allegations could have been handled with more vigor, and with greater skepticism of the Rays' explanations.

The bedroom where Sabrina died revealed evidence of locks, alarms, coverings on the doors and windows. Police discovered that she slept on a thin mattress on the floor and apparently had used a toilet in the room intended for toddlers. A DHS daycare inspector failed to check the bedroom just months before Sabrina's death because she misunderstood a policy requiring a complete examination of the house.

Some DHS workers noted during their assessments that Sabrina appeared thin, but in interviews with the Ombudsman, they acknowledged a lack of training in recognizing malnutrition. One worker in 2015 questioned whether Sabrina had visited a doctor about her condition, but closed her investigation before she received a response. Records later showed that Sabrina had only one medical visit since 2012 – an eye exam.

"There were plenty of official eyes and ears on this family," the Ombudsman's report reads. "When it came down to it, there was not sufficient communication among DHS officials."

On the few occasions when suspicious DHS workers discussed further investigation or monitoring of the Rays, there was no follow through. Even more troubling, one foster care contractor who made several abuse reports on behalf of foster children at the Ray home was silenced by her supervisors. She ultimately quit her job in frustration.

After Sabrina's death, the Rays and three family members were all convicted of crimes relating to the maltreatment of Sabrina and her siblings.

"It is no exaggeration to say this investigation brought me to tears," said Ombudsman Kristie Hirschman. "I cried at the atrocities Sabrina was subjected to, and I was angry that so many trained

officials at DHS had misplaced their trust in individuals who were so depraved. We must all do better for our children."

The Ombudsman's 146-page report made 13 recommendations to DHS to improve training, communication, and departmental protocols. Ten of the recommendations were accepted. Notably, DHS agreed to explore using medical professionals for consultation on cases. The agency also said it would take steps to ensure that welfare and child regulatory staff are alerted to any allegations of child abuse in the home.

In addition, Hirschman asked the Legislature for a second time to re-evaluate the role and funding of the state's Child Fatality Review Committee, which was established after the death of 2-year-old Shelby Duis in 2000 but has never met. She also encouraged DHS to ask state leaders for more money if it finds that its daycare licensing unit is understaffed.

The report is the Ombudsman's second major report on DHS this year involving the death of a teenage girl. The first, concerning Natalie Finn, was released in February and criticized DHS for poor documentation of abuse intake reports that led officials to close serious allegations without further investigation.

The Ombudsman's full report can be viewed at https://www.legis.iowa.gov/Ombudsman/ .

-end-