

Office of  
Inspector General of Nebraska Child Welfare

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# Annual Report

2015 – 2016

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The OIG thanks and acknowledges the Nebraska Legislature and legislative staff for continuing to provide assistance, support and advice, particularly the Health and Human Services and Judiciary committees. In addition, it should be noted that the Ombudsman's Office goes above and beyond in assisting the OIG. Also contributing to this report was our student intern, Anna Holmquist, and our UNL law student extern, Aishah Witte. A most sincere and heartfelt appreciation for all of the time, talent, and counsel that has been offered by all.

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September 14, 2016

Anyone may file a complaint with the OIG regarding concerns about specific children and cases or broad misconduct in the child welfare and juvenile justice systems. The information provided is confidential as the identity of the reporting party. A complaint may be filed online or you may call, email, or write a letter.

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September 14, 2016

Dear Governor Ricketts, Justices of the Nebraska Supreme Court, and Members of the Nebraska Legislature:

Ensuring the safety and well-being of Nebraska's children – particularly those in the state's care – is one of state government's essential duties.

Nebraska's child-serving agencies and institutions and their front-line staff – caseworkers, probation officers, detention center and Youth Rehabilitation and Treatment Center (YRTC) staff, attorneys practicing in juvenile court, and all of those providing services to children and families – are to be commended for their dedication to some of the most important and difficult work that exists in our state.

However, formidable challenges remain.

Too many of the children and families touched by our child welfare and juvenile justice systems experience tragic outcomes. During the past fiscal year, the Office of Inspector General (OIG) completed investigations involving 22 cases where children involved with the child welfare or juvenile justice system died or were seriously injured and four deaths that occurred in licensed child care facilities. The OIG also completed an investigation on deteriorating conditions and a lack of programming for some of the most troubled youth at YRTC-Kearney.

These investigations uncovered a number of systemic issues that merit immediate attention by Nebraska's leaders.

Chief among these challenges is a high caseload burden on Nebraska's child welfare workers — the front-line staff working to protect our children who are at risk of abuse or neglect. This is the fourth annual report issued by this office. And for the fourth year running, the OIG has pointed out high caseloads for child welfare caseworkers as a primary obstacle to keeping maltreated children safe and delivering quality services.

Until Nebraska's leaders commit additional resources to lower caseloads, the child welfare system – and the children and families it is designed to serve – will continue to suffer.

Our investigations also revealed the urgent need for better coordination between agencies serving Nebraska's children. The OIG found numerous instances of agencies, in essence, competing or undercutting another agency's efforts. For example, not all responses to child abuse reports were appropriately coordinated between local law enforcement and DHHS. No policies exist within Probation or DHHS to guide front line workers on how cases should be handled with which they are both involved.

Leaders of agencies – public and private and state and local – must always place the best interests of Nebraska's children above individual agency priorities, politics, and competition.

It is my hope that we can continue to learn from the tragic deaths and injuries of children contained in this report and make needed improvements to stop such incidents from happening.

DHHS has already begun to take action on recommendations the OIG has made for improvement in many of its investigative reports. However, Nebraska's child welfare and juvenile justice system are not governed by a single agency. We all must do our part to address some of the largest obstacles to ensuring the safety and well-being of children and youth in these systems.

Nebraska has enacted significant policy change and devoted additional monetary resources to reform our state's child welfare and juvenile justice systems over the past few years. I know we all want that good work to continue, and I look forward to working with you in this endeavor.

It is an honor to serve as your Inspector General of Nebraska Child Welfare. Thank you for your time and attention to this report.

Very Respectfully,



Julie L. Rogers

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# Executive Summary

The Office of Inspector General of Nebraska Child Welfare (OIG) provides accountability for Nebraska's child welfare and juvenile justice systems through independent investigations, identification of systemic issues, and recommendations for improvement.

The OIG investigates: complaints and allegations of wrongdoing by agencies and individuals involved in these systems; deaths and serious injuries of system-involved children; and other critical incidents related to children involved with the child welfare and juvenile justice systems.

The OIG is required by law to provide a summary of its investigations each year, as well as the recommendations it has made to agencies and their implementation status.<sup>1</sup> This report summarizes the work of the OIG from July 1, 2015 to June 30, 2016.

During the past year, the OIG experienced a 40 percent increase in the number of cases referred to the office for review. Each case receives a preliminary investigative review and the OIG tracks data on all incidents referred to the office (see pg. 14). However, due to capacity constraints only a small number of the 577 cases led to final investigative reports.

This summary contains highlights from this year's Annual Report, including areas where the OIG made recommendations for improvement and overviews of investigative reports that the OIG issued.

## OIG Recommendations

In its reports of investigation, the OIG makes recommendations to agencies for improvement. The OIG bases these recommendations on shortcomings identified in the investigation, as well as additional research into best practices.

By law, agencies must accept, reject, or request modification of recommendations made by the OIG within 15 days after they receive the investigative report.<sup>2</sup>

This report details 33 OIG recommendations for improvement – 29 to the Department of Health and Human Services (DHHS) and four to Juvenile Probation (Probation). DHHS accepted 28 of the recommendations and rejected one recommendation.

Probation rejected the OIG's report containing four recommendations.

The full OIG recommendations and agency responses can be found in individual investigation summaries. A complete listing of the recommendations, agency responses, and implementation status can be found in Appendix A.

Recommendations were made in the following areas:

## Caseload and Workload for Caseworkers and Other Key Staff

Numerous OIG investigations this year revealed that high caseloads and workloads were directly contributing to negative outcomes for children and families in the child welfare systems. Staff serving Nebraska's vulnerable children and families have extremely important and demanding jobs. When staff have too much work, corners get cut, things get missed, and errors are made. Although minimum caseload standards for child welfare staff were put into place four years ago, DHHS still cannot meet the threshold established in Nebraska law.<sup>3</sup>

The OIG recommended DHHS take action to ensure it has enough employees to, at a minimum, meet caseload standards for child welfare staff outlined in Nebraska law and meet staffing requirements related to the Prison Rape Elimination Act at the Youth Rehabilitation and Treatment Center-Kearney. The OIG recommended an increase in the number of supervisors at the Child Abuse and Neglect Hotline (Hotline).

Given the likely fiscal implications of these recommendations, they are unlikely to be fully implemented without leadership and commitment from those outside the agency, including the Governor and Legislature.

## Strengthening the Workforce

A skilled, stable workforce is key to delivering effective services. While reasonable caseloads are certainly part of this effort, the OIG also recommended that DHHS take additional steps to strengthen its workforce. The OIG recommended that DHHS adopt additional training in a number of key areas, including Initial Assessment, medical aspects of child abuse, and safe sleep for infants. The OIG also recommended that DHHS adopt a plan designed

to reduce caseworker turnover and adopt strategies to lessen disruption when cases transfer from one worker to the next.

## Coordination between Agencies Serving Children

The OIG found that a lack of communication and coordination between agencies, or divisions of agencies, led to negative outcomes for children. Agencies too often worked in isolation or in opposition to each other instead of sharing key information and resources that could benefit children and families. Each agency has a unique role to play and has expertise in their specific area. The OIG made a number of recommendations designed to enhance cooperation between key entities.

### *Multidisciplinary Child Maltreatment Investigations*

In Nebraska, investigating abuse and neglect is not the responsibility of DHHS alone. Local law enforcement, medical professionals, and county attorneys (among others) frequently play an important role in deciding how investigations occur and what their outcome will be. The OIG investigated a series of cases where children died or were seriously injured following a flawed multidisciplinary investigation. When unilateral decisions are made, outdated practices are adhered to, or those involved fail to effectively coordinate, tragic outcomes occur.

In order to strengthen multidisciplinary investigations, the OIG recommended that DHHS work to restructure the Children's Justice Act (CJA) taskforce, currently the Nebraska Commission on the Protection of Children, to ensure there is a statewide committee assessing and working to improve coordination on child maltreatment investigations.

The OIG recommended that DHHS better monitor the use of federal CJA funds to ensure they are reaching the areas of greatest need. The OIG further recommended that DHHS adopt a policy to clarify when using a child advocacy center to conduct interviews is appropriate.

### ***Probation and DHHS***

Currently, Probation and the DHHS Division of Children and Family Services lack policies and protocols on how to substantively coordinate cases with which they are both involved. The OIG recommended that such policies and protocols be adopted. The OIG also recommended that Probation and the Division of Developmental Disabilities increase their coordination to better serve youth with disabilities in the juvenile justice system. Having a deeper understanding of other systems that impact youth will strengthen Probation's ability to effectively supervise youth and ensure they are law-abiding and DHHS' ability to meet child and family needs related to maltreatment. A framework for cooperation on shared case management between DHHS and Probation will ensure youth in both the child welfare and juvenile justice systems get the services they need.

### ***Division of Children and Family Services and Division of Public Health***

The OIG recommended that these two divisions of DHHS better coordinate prevention efforts on two crucial topics – safe sleep for infants and pediatric abusive head trauma. Unsafe sleep and abusive head trauma were prominent causes of death or serious injury in many of the cases investigated by the OIG. Sharing knowledge, data, and resources across divisions will better ensure that Nebraska's children are safe.

## **Enhancements to Internal and External Performance Monitoring**

Collecting key data and ensuring thorough documentation of interventions with children and families is an essential part of delivering high quality and evidence-based services to children and families. Agencies should use documentation and data collection to monitor and improve their performance internally. This information also has an important role to play in ensuring government transparency. The public has a right to know how key agencies are performing and ask for improvements.

A number of investigations this year showed the need for expanded internal performance monitoring or data collection in key areas.

### ***Probation***

Probation's current statewide data collection and internal performance monitoring efforts are limited in scope. Probation has a limited number of statewide quality assurance staff who can review cases and does not collect or consistently review key data measures at the state level.

The OIG recommended Probation adopt statewide policy or protocols on documentation and record keeping to ensure key information is consistently captured in a timely manner across the state. This will greatly improve both internal and external ability to monitor the quality of Probation interventions and policy compliance.

The OIG also recommended Probation expand its statewide quality assurance and performance monitoring capacity, so that it can track key measures such as how many youth have completed individualized case plans or had timely home visits on a monthly basis.



## **DHHS**

The OIG recommended that DHHS strengthen its current quality assurance efforts in a few specific areas. YRTC-K currently lacks strong Central Office oversight. The OIG recommended this be remedied in part by implementing a continuous quality improvement data monitoring process (administered by Central

Office), as well as moving towards a system of digital record keeping. The OIG recommended expanding data collection on the Hotline and on high or very high risk cases that do not have an ongoing case opened. The OIG also recommended that DHHS contract for an independent validation study of its SDM tool – a set of assessments to measure safety and risk – now that it has been in use for a number of years.

## OIG Investigations, 2015-16

During Fiscal Year 2015-16, the OIG completed full investigations of 22 cases of system-involved children who died or were seriously injured and 4 investigations of deaths in licensed child care facilities. Some investigations were grouped together into reports because they dealt with similar system issues or types of cases.

Five reports related to 25 deaths or serious injuries were issued to the Department of Health and Human Services (DHHS) in 2015-16. One youth whose death was investigated by the OIG was served by both Administrative Office of Probation (Probation) and DHHS. A report related to this case was issued to Probation in 2015-16. A separate report was issued to DHHS related to this case early in the 2016-17 fiscal year. A summary of this investigation is also included in this Annual Report.

The OIG also completed a full investigation on allegations of wrongdoing at the Youth Rehabilitation and Treatment Center-Kearney, which was submitted to DHHS.

Detailed summaries of each investigation can be found later in this report. For the purposes of this report, some individual investigation summaries have been combined.

Here are the highlights from those reports:

### Serious Injury of Child after 11 Reports of Alleged Physical Abuse

A 4-year-old, whose family had recently agreed to participate in a voluntary child welfare case, was admitted to the hospital with a skull fracture and bruising all over his body. The subsequent investigation revealed that his father was responsible and had repeatedly physically abused him.

In the six months before the injury, the Hotline had received 11 reports of alleged physical abuse of the 4-year-old by his father, five of which were investigated by DHHS, law enforcement, or both.

In this investigation, the OIG found that:

- The Hotline made errors that either delayed or prevented injuries from being assessed, leading them to dismiss the child's recurring injuries.
- Medical information was repeatedly misinterpreted by DHHS and law enforcement,

- Investigations into the possible abuse were flawed. Key evidence was not gathered, including photographs of the child’s injuries. Interviews were not appropriately conducted.
- DHHS staff did not fully rely on their assessment tool to guide decisions about child safety.
- A slow transition to ongoing case management meant that even though a case was open when the child’s serious injury occurred, no supports or services were being provided to the family.

## Death and Serious Injury after a Child Maltreatment Investigation

Between June 2013 and June 2015, 11 Nebraska children who had recently been the subject of a child abuse or neglect investigation died or were seriously injured.

After each of the DHHS investigations (also called Initial Assessments), no case was opened to offer ongoing services to the families. In all of the cases, the injuries were caused by abuse or neglect.

Through its investigation of the two deaths and nine serious injuries, the OIG found:

- Children age 3 and under were the victims in every case. The OIG found specific challenges which limited the effectiveness of Initial Assessments with very young children, especially low community visibility.
- Physical abuse by the child’s father or mother’s male partner was the cause of injury in the majority of cases. Assessment of the perpetrators was often limited before the death or serious injury.
- Half of the families scored as high risk for future abuse or neglect by DHHS. However, even those that scored as moderate risk had significant risk factors for abuse and neglect present.
- Most children injured lived in rural communities, which impacted Initial Assessment practice and families’ access to resources.
- In half of the cases, the Hotline received an additional call between the Initial Assessment closing and the death or serious injury. Errors were made that limited DHHS’ ability to appropriately screen calls.
- Every investigation conducted before a death or serious injury involved law enforcement, medical professionals, or both. Poor coordination with or poor practice by these entities contributed to bad outcomes in many cases.
- Initial Assessment policy and procedure were not consistently followed. Required documentation was not gathered and interviews with key collateral contacts did not occur.
- Initial Assessment and mixed caseloads do not comply with state law. High caseloads negatively impact the ability to do thorough, quality work and follow DHHS policy.

## Sudden Unexpected Infant Deaths

Between May 2013 and December 2015, the OIG received 11 reports of infants dying suddenly and unexpectedly – seven who had prior or current child welfare involvement and four who died in licensed child care centers.

These types of cases are often referred to as sudden unexpected infant death (SUID), and usually occur in an unsafe sleep environment.

The OIG found that:

- Unsafe sleep practices were present in every child death investigated for this report.
- Licensed child care centers have three years to take safe sleep training after opening. Some providers lacked important knowledge about infant safe sleep.
- The Division of Children and Family Services and its contractor, Nebraska Families Collaborative, lacked training, resources, and policy on promoting infant safe sleep and prevention of SUID.

## State Ward Suicides

The OIG investigated two youth suicides in the past year.

In one case, a 16-year-old state ward committed suicide by hanging herself in her bedroom in her family home. The autopsy found amphetamines in her system and a blood-alcohol level nearly twice the legal limit.

In this case, the OIG found that:

- Little was done to ensure the state ward was accessing mental and behavioral health treatment for which she had been referred.
- DHHS lacked policies and procedures on coordinating behavioral and mental health care, including oversight of psychotropic medications.
- Family stressors impacting the youth were not adequately addressed during case management, including the mother's work schedule, limited ability to speak and understand English, and cultural barriers in the youth's home.
- The youth had three DHHS caseworkers in the month before her death, which led to instability and mismanagement during a critical period.

In the other case, a 17-year-old state ward committed suicide by hanging himself outside of a psychiatric residential treatment facility, where he lived at the time.

The DHHS Division of Child and Family Services (CFS), the Division of Public Health, and Magellan Behavioral Health — under contract with the Division of Medicaid and Long-term Care — each conducted investigations after the youth's suicide. The OIG concurred with these findings, which concluded that there was:

- Inadequate training of some staff and supervisors at the facility.
- Failure to implement or follow emergency response policies and procedures.

## Death of Youth Served by Probation & DHHS

A 16-year-old supervised by Probation had been under CFS case management up to two days before his death, was receiving voluntary services from the DHHS Division of Developmental Disabilities, and placed in out-of-

home care. The youth died due to hypothermia while on a weekend visit with family. The autopsy found acute ethanol intoxication was a contributing factor in the death.

The OIG prepared two separate death reports for DHHS and Probation related to this case. Probation's report was issued during the 2015-16 fiscal year, and the report to DHHS was issued early in the 16-17 fiscal year. Both summaries were included in this year's report to ensure that the case was accurately and completely represented.

Through its investigation into Probation's involvement in the case, the OIG found:

- A lack of Probation policies, procedures, and training on working with youth with developmental disabilities and youth involved with the child welfare system. This limited Probation's ability to effectively work with and supervise the youth.
- Confusion about roles and responsibilities of different entities led to a lack of coordination in providing effective and timely services to the youth and family.
- Probation's policy on home visits, family engagement, and case management was not followed.
- A lack of documentation on how Probation worked with the youth and family. This limited the OIG's ability to fully assess whether all Probation policies, protocols, and procedures were followed.

Through its investigation into DHHS' involvement in the case, the OIG found:

- Disagreement and confusion between CFS and DD, and CFS and Probation prevented the youth's needs from being identified and met in a timely manner.
- CFS lacked policy and training on key issues, including coordination with Probation and Developmental Disabilities.
- Issues for the youth went unidentified since staff lacked the tools to effectively coordinate cases.
- CFS did not comply with its own required timelines on assessments and case planning.

## Deterioration of Conditions at the Youth Rehabilitation & Treatment Center- Kearney

During the 2015-16 fiscal year, the OIG experienced a more than 300 percent increase in complaints and critical incidents related to the Youth Rehabilitation and Treatment Center-Kearney (YRTC-K), Nebraska's residential facility for boys in the juvenile justice system.

The OIG initially opened an investigation into the treatment being provided to five youth at the facility who were the frequent subject of complaints or the subject of reports of concerning incidents, or both.

As the investigation revealed deeper issues, it was expanded to focus on the administrative oversight and decision-making that allowed a deterioration of conditions and violations of state law at YRTC-K to go unchecked while the facility was without a full-time administrator.

The OIG's investigation into YRTC-K revealed:

- Key data measures significantly worsened while YRTC-K was without a full-time administrator;
- The decision to remove the prior facility administrator was made hastily and under outside pressure, without adequate consideration for the impact it might have on the youth and facility;
- There was no appropriate plan in place for how YRTC-K would operate under interim administration;
- The Office of Juvenile Services (OJS) Administrator was not able to fulfill job duties related to YRTC-K, leaving the facility without appropriate oversight;
- Central Office administrators were unaware of the specifics of programs and planning at YRTC-K that were unlawful and producing negative outcomes for youth; and
- Youth at YRTC-K, especially those living full-time in the Dickson Unit, were continually subject to conditions that were not compliant with Nebraska law, DHHS regulations and operating procedures.

## Concluding Remarks

This annual report highlights only those issues that were a special focus for the OIG in the past year, including an "Issue Spotlight" surrounding questions about parental rights in juvenile justice cases. It is the OIG's hope that this report sheds light on needed improvements to the systems serving children and families. In the coming year, the OIG will continue its work to increase accountability and recommend responsible solutions to ensure the high-performance of the systems that serve our state's most vulnerable.

Through the cases it reviews and the committees on which the Inspector General serves, the OIG knows that challenges beyond those mentioned in this report face Nebraska's child welfare and juvenile justice systems. The OIG looks forward to the work of agencies, committees and policy makers to identify and take action to solve some of these issues.

## Overview: Office of Inspector General of Nebraska Child Welfare

In 2012, the Office of Inspector General of Nebraska Child Welfare (OIG) was created to provide increased accountability for the state's child welfare system. In 2015, the OIG's jurisdiction was expanded to include state-funded juvenile justice operations. Housed within the legislative branch, the OIG seeks to promote accountability, transparency, good government, and high performance in the child welfare system through independent investigation and performance review.

By law, the OIG investigates allegations or incidents of misconduct, misfeasance, malfeasance, statutory violations, and regulatory violations related to child welfare or juvenile justice committed by any of the following:

- Nebraska Department of Health and Human Services (DHHS);
- Administrative Office of Probation (Probation);
- The Commission on Law Enforcement and Criminal Justice;
- Private agencies and service providers under state contract;
- Licensed child care facilities;
- Foster parents; and
- Juvenile detention and staff secure detention centers.

The OIG is also required to investigate deaths and serious injuries of children and youth who were recently involved with the child welfare or juvenile justice system. In its investigations, the OIG identifies systemic issues and makes recommendations for improvement to prevent similar tragedies.

The following section of the Annual Report provides information on the operations of the OIG during fiscal year 2015-16. This includes cases reviewed by the OIG in the past year, recent changes to statutes impacting the office, information on the committees aimed at system improvement on which OIG staff serve, and the OIG's capacity challenges.

### Cases Reviewed by the Office of Inspector General, 2015-16

The work of the OIG is largely determined by the intake information that it receives. Information generally comes to the office in the form of "critical incident" notifications from DHHS or Probation, complaints from the public, and copies of grievance findings from DHHS.

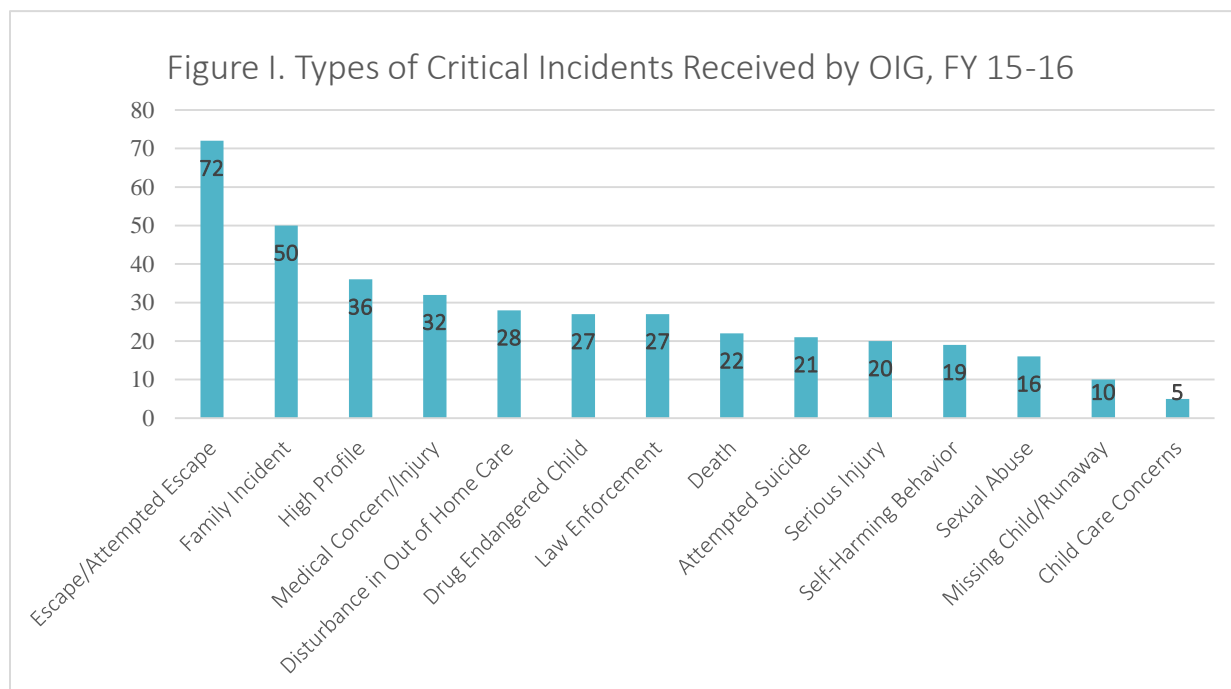
Between July 1, 2015 and June 30, 2016, the OIG received a total of **577 intakes**, a 40.7 percent increase from the previous year. The intakes received included:

- **385** critical incidents (39.5 percent increase);
- **155** complaints (17.4 percent increase);
- **24** reports of or requests for information (a new category this year); and
- **13** grievances and accompanying findings from DHHS (550 percent increase).

The OIG conducts a preliminary investigation, including a document review on every complaint, critical incident, and grievance finding to determine whether or not the case rises to the level of a full investigation, and what, if any, additional actions may be appropriate.

### Data on Critical Incidents

Critical incident reports bring a range of issues to the OIG’s attention. Figure I. below shows the type of concerns included in the 385 reports that came to the OIG’s notice in the past year.



These reports involved 317 different youth. Thirty-six youth were involved in multiple incidents reported to the OIG over the course of the year.

Generally, the youth who had multiple critical incidents were either involved with both DHHS and Probation -- triggering a critical incident from each agency-- or had multiple incidents over the course of the year.

Twenty-two of the youth who had multiple incidents were housed at one of the YRTC's.

As with last year, the highest number of incidents reported to the OIG involved a

youth escape or attempted escape. The total number of escapes reported to the OIG grew from 47 last year to 72. Sixty-two of the 72 escapes or attempted escapes occurred at the YRTC-Kearney.

Other types of incidents most frequently reported were incidents of concern related to family members of youth in DHHS custody (e.g. accident or medical issue, criminal arrest) or other “high profile” events (e.g. media coverage of child abuse cases).

The OIG saw an increased number of medical concerns and injuries, suicide attempts, serious self-harming behavior, and children exposed to

dangerous levels of drugs reported over the past year.

Currently, there is an increase in the number of suicide attempts of system-involved youth. From fiscal 2014-15 to 2015-16, the suicide attempt category went from 17 to 21. So far this fiscal year, there is an upward trend of suicide attempts. Ten state wards attempted suicide in July and August of 2016 alone.

Finally, the OIG received over 40 reports of child death or serious injury which will be further detailed in following sections.

**Table I. Placement at Incident**

PLACEMENT	CRITICAL INCIDENTS
Family Home	149
YRTC	132
Out-of-Home Placement	90
Child Care Center	6
Detention Center	4
Unknown	4

As indicated in Table I., most critical incidents reported to the OIG this year occurred in family homes, at the YRTC-Kearney, or in out-of-home placement (including group homes, shelters, and treatment facilities).

343, or 89 percent, of the critical incident reports came from DHHS, while Probation sent 41 critical incident reports. One additional critical incident report was received from a local jurisdiction.<sup>4</sup>

Table II. shows the level of system involvement youth involved in critical incidents had at the time of the incident. Probation youth committed to YRTC made up the largest number, followed by state wards, youth on Probation, and children with no prior system involvement.

**Table II. System Involvement at Incident**

SYSTEM INVOLVEMENT	CRITICAL INCIDENTS
Probation Youth Committed to YRTC	123
State Ward (3a, OJS, or 3c)	67
None	44
Probation Youth	42
Prior Initial Assessment	32
Dually Adjudicated (Probation and DHHS)	22
Prior Child Abuse Report	21
Open Non-Court Case	20
Former Ward	9
Aftercare	5



## Deaths Reported to the OIG

The OIG is required to investigate all deaths and serious injuries of system-involved children who are: (1) placed in out-of-home care, a licensed residential facility, or in the care of a licensed child care facility; (2) currently receiving or have received child welfare services from DHHS in the past twelve months; (3) currently receiving or have received services from the Juvenile Services Division of Probation in the past twelve months; and (4) the subject of a child abuse investigation (initial assessment) in the past twelve months.

During the last fiscal year, the OIG received reports of **20 child deaths** from 22 critical incident reports. The OIG received critical incidents from both Probation and DHHS related to two of the child deaths. (Last year, the OIG received reports related to 21 child deaths.) Of the past fiscal year's deaths reported to the OIG:

- **65 percent** involved children **under the age of five** (45 percent were under the age of 2);
- **72 percent** of the children were **male**;
- **25 percent** had no prior system involvement; and,
- **13** deaths met the criteria for a full OIG investigation.

Most of the 13 full investigations into these deaths are not yet final, however the OIG has preliminary data available on the cause of death and level of system involvement (see Table III.). The OIG will complete full investigations in these cases to identify issues in the individual cases and areas where systemic improvements are needed to better care for Nebraska's children.

Table III. Cause of Child Death, FY 15-16

	State Ward	Probation Supervision	DHHS Non-Court Services	Initial Assessment in Past 12 months	Licensed Child Care Facility	DHHS Closed Case in past 12 months
Abuse or Neglect	1	0	1	0	0	0
Homicide - Firearm	0	2	0	0	0	0
Medical	0	0	0	0	1	1
Sudden Unexpected Infant Death (SUID)	0	0	1	2	2	0
Suicide	0	1	0	0	0	0
Unknown	0	1	0	0	0	0
<b>Total</b>	<b>1</b>	<b>4</b>	<b>2</b>	<b>2</b>	<b>3</b>	<b>1</b>

## Serious Injuries Reported to the OIG

The Office of Inspector General of Nebraska Child Welfare Act defines a serious injury as, “injury or illness caused by suspected abuse, neglect, or maltreatment which leaves a child in critical or serious condition.”<sup>5</sup>

During the last fiscal year, the OIG received reports of **20 suspected serious injuries, a 41 percent decrease** from the 34 during the last fiscal year. Of these reports:

- More than **75 percent** involved children **under the age of 2** (95 percent under the age of 5);

- **65 percent** of children injured were female;
- More than **55 percent** (11 of 20 injuries) involved children who had no prior contact with the child welfare or juvenile justice system; and
- **5** met the criteria for a full OIG investigation.

Table IV. shows information available on the type of system involvement in cases where the OIG opened a full investigation.

**Table IV. System Involvement in New OIG Serious Injury Investigations, FY 15-16**

State Ward	Probation Supervision	DHHS Non-Court Services	Initial Assessment in Past 12 months	Licensed Child Care Facility	DHHS Closed Case in past 12 months
0	0	1	2	0	2

## Complaints Received by the OIG

The OIG has jurisdiction to look into “allegations or incidents of possible misconduct, misfeasance, malfeasance, or violations of statutes or of rules or regulations,” by:

1. DHHS;
2. Juvenile Probation;
3. The Nebraska Commission on Law Enforcement and Criminal Justice’s juvenile justice programs;

4. Private child welfare agencies, foster parents, licensed child care facilities, and contractors of DHHS and Juvenile Probation; and,
5. Juvenile detention and staff secure detention facilities.<sup>6</sup>

In the past year, **the OIG received 155 complaints**, 134 of which it had the jurisdiction to investigate. Table V. shows the number of complaints received related to different entities.

Table V. Subjects of Complaints, FY 15-16

AGENCY	#
DHHS	98
Probation	20
Court (no jurisdiction)	17
Private Service Provider	15
Other Agencies (no jurisdiction)	4
Detention Center	1

Table VI. Complainant's Relationship to Case or Child

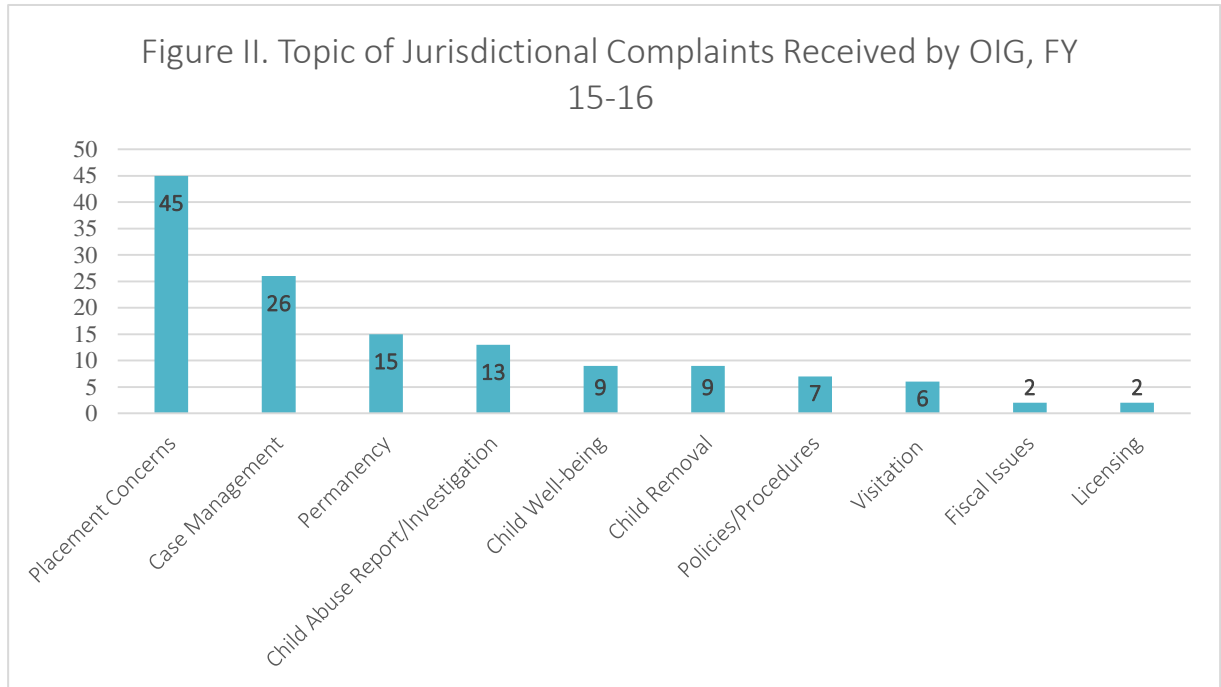
COMPLAINANT	#
Parent	66
Grandparent/Relative	31
Member of Public	9
System Professional	8
Attorney	6
Foster Parent	6
Legislative Staff	6
Advocate	5
Child Care Provider/Educator	5
Health Care Professional	5
Internal	5
Anonymous	1
Youth	1

The OIG received **complaints from citizens in 23 of Nebraska's 93 counties**, in addition to 13 complaints received from those residing in other states.

As illustrated in Table VI., complaints were primarily made by parents, grandparents, and other relatives concerned about the children or cases they brought to the OIG's attention.

As shown in Figure II. (next page), the OIG received complaints on a range of issues. The complaint most frequently received related to concerns about a child's placement.

Other common complaint trends related to concerns about how cases were being managed, whether permanency plans for children were appropriate, and whether appropriate action was taken during the screening of child abuse reports or child abuse investigations.



### Alternative Response Cases

The Legislature explicitly tasked the OIG to investigate complaints and incidents of concern related to cases referred to Alternative Response, a new pilot project that DHHS began in October 2014, and to report those findings annually.<sup>7</sup> The OIG received no complaints, critical incidents, or grievances related to Alternative Response during the past fiscal year.

## Recent Changes to Statutes Impacting the OIG

### Changes in Access to Juvenile Probation Records

In 2015, the Legislature passed LB 347, which added Juvenile Probation operations to the OIG's jurisdiction. The law became effective on August 30, 2015. However, the Administrative Offices of Probation and the Courts notified the OIG in September 2015 that they were not able to give the OIG access to electronic or paper files, and the OIG was denied access to policies and procedures regarding juvenile probation.

In March 2016, the Legislature passed LB 954 to address the Judicial Branch's concerns with Juvenile Probation functions being subject to OIG investigations. The law, which went into effect on March 7, 2016, requires a court order be issued before the OIG is given access to Probation case records, whether electronic or paper.<sup>8</sup> Appendix E contains an updated version of the Office of Inspector General of Nebraska Child Welfare Act.

Beginning in January 2016, the Administrative Office of Probation began to publically post its [Juvenile Probation Policies](#) online.<sup>9</sup> By February 2016, the OIG was provided copies of Juvenile Probation Protocols and Forms, which are expected to be used statewide to govern how cases are managed and decisions

made. The OIG was also given access to the New Probation Officer Training Curriculum. The Administrative Office of Probation requires individual Probation Districts to establish Processes for carrying out Policy and Protocol. Such processes for the 12 Probation Districts were made available to the OIG in June 2016.

### Added Responsibilities Related to Juvenile Room Confinement

In 2016, LB 894, which provides new guidelines related to juvenile room confinement in Nebraska, was signed into law. Included in these guidelines are requirements for how data on room confinement is reported and collected by juvenile facilities, which include detention centers, prisons, YRTCs, and group homes.

The law now requires Nebraska's juvenile facilities to submit reports to the Legislature quarterly. The OIG is charged with reviewing and analyzing the data, and issuing a report on its findings annually.

To aid in implementation, the OIG created standard definitions for data collection and reporting on room confinement and distributed them to Nebraska's juvenile facilities. This data collection guide and the corresponding statutes can be found in Appendix D.

### OIG Capacity Challenges

The OIG continuously struggles with the tension that arises when there are standards that need to be set and reached to perform quality work of an inspector general's office while managing expectations of thoroughness and timeliness of full investigations. Currently, from the time a child dies or is seriously injured, with current capacity, it is at the very least an entire year and a half before a full investigative report is complete. There is little to no capacity to complete full investigations on child welfare or juvenile justice issues that arise outside of death or serious injury unless those death and serious injury investigations are put on hold. The OIG does its best to prioritize workload by organizing investigations into categories and arranging a timeline of completion for those specific investigations.

### Committee Membership & Participation

In addition to investigations, reviews, and evaluations, the OIG participates in several initiatives or attends meetings of groups created to elevate the workings of various areas in serving children and youth in the state's care. Most notably, these include:

- Nebraska Children's Commission (statutory member)
  - Normalcy Task Force Grievance Sub-Committee
- Child and Maternal Death Review Team (statutory member)
- LB 265 Data Advisory Group (statutory member)
- Nebraska Supreme Court Commission on Children in the Courts
- Statewide Juvenile Detention Alternatives Initiative
- Division of Children & Family Services Director's Alternative Response Steering Committee
- CQI and Operational Meetings at DHHS
- Cross System Collaboration Meetings

# INVESTIGATION SUMMARIES

2015-16

## Overview of Investigations

During the 2015-16 fiscal year, the Office of Inspector General of Nebraska Child Welfare (OIG) issued seven investigative reports. Six reports were issued to the Department of Health and Human Services (DHHS) and one report to Administrative Office of Probation (Probation). This section of the Annual Report contains detailed summaries of each investigative report, including:

- Summaries of individual deaths and serious injuries;
- Investigative findings;
- Detailed recommendations the OIG made to agencies in each report;
- Full agency responses to each recommendation; and,
- Information the OIG has gathered on the implementation status of each recommendation.

Five of the reports sent to DHHS related to 11 deaths and 10 serious injuries of children or youth who had recent contact with the child welfare system and 4 deaths that occurred in licensed child care facilities. The remaining report issued to DHHS concerned a deterioration of conditions and noncompliance with statutes at the Youth Rehabilitation and Treatment Center-Kearney.

The OIG made 29 recommendations to DHHS in the reports below. DHHS accepted 28 recommendations and rejected one.

The single report issued to Probation concerned the death of a youth who had been under both Probation supervision and CFS care. The OIG made four recommendations to Probation in the report. Probation rejected the report. This investigation and analysis shows how a case can be more difficult to manage when multiple agencies are involved, and where lines of responsibility are unclear.

Information on all of the recommendations made to agencies as well as their implementation status can also be found in Appendix A.

## OIG Investigative Report Process

The Office of Inspector General of Nebraska Child Welfare Act (Appendix E) sets out duties for the OIG. This includes investigating allegations or incidents of possible misconduct, misfeasance, malfeasance, or violations of statutes or of rules or regulations, and deaths and serious injuries of children who recently had contact or involvement with the child welfare or juvenile justice system.

The OIG opens investigations based on the cases referred to it by agencies and members of the public. After a preliminary review conducted by OIG staff, a decision is made on whether to open a full investigation. A full investigation, at a minimum, includes:

- Comprehensive review of all documents relevant to a case -- from agencies, local law enforcement, and others;

- Investigative interviews with key personnel involved in the case;
- Review of relevant Nebraska statutes, and agency rules, regulations, policies, procedures, and protocols; and
- Additional research on best practices to formulate recommendations.

At the conclusion of a full investigation, which can range from several weeks to a few months, the OIG issues an investigative report to the agency involved. Within 15 days, the agency must respond to the OIG and accept, reject, or request modification of the OIG's recommendations.



## Investigation Summary: Serious Injury of Child after 11 Reports of Alleged Physical Abuse

A 4-year-old child was admitted to the hospital with a skull fracture and bruising all over his body. During the subsequent investigation, the child revealed that his father had been repeatedly physically abusing him and had caused the skull fracture.

In the six months before the injury, the Child Abuse and Neglect Hotline (Hotline) had received 11 reports of alleged physical abuse of the 4-year-old by his father, five of which were investigated. In each case, the Department of Health and Human Services (DHHS) or law enforcement incorrectly concluded no physical abuse occurred.

The child had been diagnosed with special needs and developmental delays, which made it difficult for professionals to communicate with him during investigations into child abuse reports. A few weeks before the injury, DHHS had gotten the family to agree to a voluntary (or non-court) case, but services had not yet been provided.

### Investigative Findings:

*The Hotline incorrectly screened a number of reports of possible abuse.*

The Hotline is responsible for receiving reports of child maltreatment and deciding whether they should be accepted for Initial Assessment (also called an investigation) based on the information the caller provides. The Hotline is also responsible for determining how soon DHHS' Division of Children and Family Services (CFS) staff in the field must make contact with the child (called priority response time). The OIG found errors by the child abuse Hotline that either delayed law enforcement and DHHS response or inappropriately screened out the report so that no assessment was done.

Three of six accepted abuse reports were assigned the wrong response time by the Hotline. In all three cases the reports alleged that there was a child victim under the age of six with an injury to the head or torso. The Intake Screening Policy and Procedures Manual states that these reports are to be screened as "Priority 1," which requires the CFS caseworker

to make contact with the child and caretaker within 24 hours. Although these reports met this criteria, they were instead screened as a "Priority 2" or a multiple reporter, delaying when CFS made contact with the child.

In one case, the Hotline screened out a report that had already been accepted for assessment based on a law enforcement contact. This was a violation of DHHS policy which stated that: "the assessment will be completed regardless of the information obtained by the law enforcement contact." The Hotline also relied on inaccurate information provided by local CFS staff and law enforcement to screen out a number of other abuse allegations.

*DHHS and law enforcement used incomplete and inaccurately interpreted medical information to dismiss allegations of physical abuse.*

All of the reports in the six months before the child's serious injury – both screened out and accepted – alleged physical abuse based on

suspicious injuries, primarily bruises. CFS staff and law enforcement used incomplete or inaccurately interpreted medical information provided by the child's father as a primary justification for accepting the family story that the injuries were accidental, rather than inflicted.

While bruises are fairly common in preschool-aged children, abusive bruises can generally be distinguished based on their location and pattern. Abusive bruises in walking children, "tend to be away from bony prominences and involve the head, neck, face, followed by the buttocks, trunk, and arms."<sup>10</sup> Patterns of abusive bruises may show outlines of hand prints or objects used to hit the child.

Nearly all of the reports alleging abuse in this case describe injuries that fall into categories common for abusive bruises. However, without gathering documentation from medical providers, DHHS and law enforcement believed that the repeated bruises were due to the child's diagnosis of "chronic eustachian tube dysfunction" – fluid blockage of the middle ear – which can cause balance issues, due to the father's assertion this condition made his son "clumsy." Thus, DHHS and law enforcement discounted the severity, frequency, and location of bruises when told that the child's condition made him clumsy.

DHHS and law enforcement also relied on an anemia diagnosis to explain bruising. The OIG confirmed with a child abuse pediatrician that anemia does not cause easy bruising in children. According to the pediatrician, this is a common "old wives' tale," which has no medical basis. In fact, anemia is often a red flag for abuse and neglect, indicating either an inappropriate diet and nutrition, or possibly ongoing injuries over a sustained period of time.

### *Investigations into the possible abuse were flawed.*

In the six months before the serious injury, numerous investigations into possible physical abuse were conducted by law enforcement and DHHS separately and jointly. Law enforcement conducted independent investigations or welfare checks alone on two allegations. DHHS conducted independent assessments/investigation on two reports. The two agencies investigated an additional three reports together.

The investigations were hampered by a poor relationship between DHHS, law enforcement, and the child care center that was often the party reporting suspected abuse. DHHS and law enforcement had a history with the center and felt they were inclined to exaggerate or report minor concerns, leading them to dismiss concerns. The child was not interviewed at a child advocacy center despite repeated injuries and documented special needs, which made interviews particularly difficult. No photographs were taken of the injuries during most investigations. Interviews were not completed with other key parties to the case, including siblings, other adults living in the household, and non-custodial parents in order to gather additional information.

### *Use of safety and risk assessments was incomplete.*

Since 2012, DHHS has used Structured Decision Making<sup>®</sup> (SDM), a nationally-recognized set of assessments to measure safety and risk. These tools are used to guide decisions about whether or not a safety plan is required, whether or not to keep the child in the home, and whether to open a case after the Initial Assessment is complete.

The OIG found that CFS made a number of errors in how it used SDM during the Initial Assessments in this case.

DHHS failed to appropriately note a number of factors that made the child particularly vulnerable to abuse and neglect on the safety assessment – including a diagnosed developmental disability and low visibility in the community due to repeated absences from school. DHHS also did not request that an ongoing case be opened, even though the risk assessment indicated the family was at high risk of future maltreatment and qualified for ongoing services.

*Ongoing services and supervision were slow to be put into place.*

A few weeks before the serious injury, the father had agreed to receive voluntary (or non-court)

services from DHHS on an ongoing basis. The file review showed that between the initial conversation with the family about receiving ongoing services and the injury three weeks later, services had not been provided to the family despite another report of possible physical abuse to the Hotline. An interview with the caseworker who was conducting the investigation revealed that the case had yet to be transferred to the ongoing caseworker, and while she had discussed implementing parenting classes, no supports had been put into place. If the transition happened more quickly or services put into place while the Initial Assessment process was being finalized, perhaps the serious injury may have been prevented.

## OIG Recommendations/Agency Response:

### 1. Implement training on the medical aspects of child abuse.

One of the repeated errors found in this investigation was the misuse and misinterpretation of medical information to dismiss reports of child abuse. This issue does not seem to be isolated to this case. The OIG interviewed a local pediatrician, specializing in child abuse pediatrics, who expressed an opinion that there is a general lack of expertise amongst both DHHS staff and law enforcement when it comes to recognizing physical abuse. While there are certainly some workers and some law enforcement officers who do a thorough job, there is a general lack of knowledge in many parts of the state, spanning both rural and urban areas. One example the pediatrician shared was that many of the professionals from DHHS and law enforcement are unaware that infants who are not yet mobile should not have any bruises. In very young children, even a small mark that does not appear serious can be a crucial warning sign.

The OIG reviewed the current training curriculum for staff developed by the Center for Children, Families, and the Law (CCFL). While there are a few parts of the training that touch on the medical aspects of child abuse, the information is limited. A good portion is devoted to abusive head trauma, while key information such as the differences in bruises in children based on age, and detailed information about bruise location and patterning is skimmed over or not mentioned. In some instances, the information contained in the training was incorrect. For example, there is a slide on the age dating of bruises based on color. The OIG confirmed with medical professionals that current accepted research has discredited this practice as unreliable.

The OIG recommends that DHHS develop training for workers on the medical aspects of child abuse and neglect to improve staff proficiency in identifying and distinguishing between injuries that are not concerning and those that are likely hallmarks of something more concerning. This training should also contain specific information on how to work effectively with medical professionals by asking the right questions, and effective ways to gather and document medical information. While Project Harmony has already developed a training on medical aspects of child abuse that they provide free of charge in Omaha, they report that very few DHHS staff have attended. The OIG recommends that DHHS require or develop a similar training (and perhaps expanded training) for at least CFS staff who are involved in the Initial Assessment process throughout the state. It is suggested that ongoing caseworkers receive similar training.

### **Agency Response: Accept**

DHHS accepts this recommendation and will continue to work with the CCFL on enhancing current curriculum provided to new workers regarding how to work with medical professionals in identifying and distinguishing between serious, hallmark types of injuries and those injuries that are not of concern or related to abuse and neglect. On Sept. 15, 2015, DHHS requested the following information of CCFL:

- A review of and consultation with Dr. Suzanne Haney regarding the "slide on the age dating of bruises based on color," as the OIG confirmed with Dr. Haney that current accepted research has discredited this practice as unreliable.
- A review of the training curriculum to ensure that training adequately and accurately addresses the following items regarding medical aspects:
  - i. Distinguishing between accidental and abusive bruises
  - ii. Bruises in babies
  - iii. Patterned bruises and
  - iv. Color of bruises
- A summary of the review currently being conducted by CCFL on all curriculum containing the medical aspects of child abuse and neglect, including recommended changes.

The "medical aspects of child abuse and neglect" was at one time, a separate standalone component of the new worker training curriculum. In June 2014, DHHS in collaboration with CCFL, made the decision to integrate the medical aspects training throughout the new worker training curriculum.

### **Status Update: *Progress***

In January 2016, DHHS updated its "Introduction to Maltreatment" training for new workers, provided by CCFL, to include information on the medical aspects of child abuse. CCFL is also in the process of contracting with Dr. Suzanne B. Haney a child abuse and neglect Pediatrician for consultation regarding the training delivered related to this topic.

## 2. Adopt policy on photographing injuries during Initial Assessment.

Most injuries leading up to the serious injury in this case were never documented by photographs. Interviews with CFS staff and law enforcement revealed that photographing injuries to children only happens consistently with injuries that are more serious or critical in nature. For most “minor” physical abuse reports, DHHS staff do not receive or take photographs or request law enforcement document them. Caseworkers have to write the description of the injuries, which is then reviewed by the supervisor to make decisions on substantiation and case closure.

When law enforcement conducts an investigation photographs should be taken of *all* injuries alleged to be from physical abuse. The OIG recommends that DHHS develop a policy to ensure all available photographs are obtained from law enforcement in any case where a child is injured. The OIG also recommends this policy establish a process for photographing injuries when law enforcement declines to respond or has failed to take photographs. Photographs of child injuries are important evidence both when DHHS requests a court filing from the county attorney’s office, and when a report of abuse is agency substantiated, which results in a perpetrator being placed on the Central Registry.

### **Agency Response: Accept**

DHHS accepts this recommendation and, as was stated in the June 5, 2015 DHHS report to the OIG, DHHS is in the process of conducting the research necessary to develop protocol regarding how photographs will be used to document physical injuries that may be the result of child abuse/neglect as well as the storage of such photos.

### **Status Update: Complete**

In February 2016, DHHS adopted [Program Memo #5-2016](#), “Use of Photographs from Intake through Case Closure,” which lays out how and when photographs are to be obtained and stored in CFS cases and investigations.

## 3. Develop additional training for Initial Assessment staff.

Initial Assessment is a particularly crucial part in the life of a case, requiring thorough and timely assessment, gathering a great deal of information involving complicated dynamics, interviewing and engaging children and family members, and coordination with many other professionals, especially law enforcement. In Nebraska, no specialized training exists for CFS caseworkers and supervisors who primarily or exclusively do work on Initial Assessment. The CCFL curriculum for new workers provides the same training to all new caseworkers, whether they will be working with ongoing case management, Initial Assessment, or a combination of types of cases.

After a review of the current CCFL curriculum, the OIG recommends that additional training be developed and required for Initial Assessment staff, especially new workers. The OIG recommends that more attention be spent on interviewing skills for families and especially children who may have limited communication skills due to age or disability. The OIG also recommends that DHHS strongly consider

including curriculum on gathering evidence and substantiating allegations, coordinating with law enforcement, and engaging families who qualify for ongoing services but are reluctant to engage.

### **Agency Response: Accept**

DHHS accepts this recommendation and is continually collaborating with CCFL to review and enhance the quality of training delivered to caseworkers. The current new worker training curriculum does contain a variety of specialized training for caseworkers who conduct Initial Assessments. DHHS also recognizes that it is important that all caseworkers receive this specialized training as staff, especially in the rural areas of the state, are required to be on-call and respond to new allegations of child abuse and neglect. The following modules are specialized training for those staff who may be conducting Initial Assessments:

- Module 1: Initial Assessment Case Management Process Overview
- Module 2: Assessing the Household and Caregiver for Safety and Need for Intervention
- Module 4: Risk and Prevention Assessments
- Module 5: Case Status Determination and Case Transfer/Closure
- Field Experience Opportunities: Initial Assessment Focus
- Interviewing and Interviewing Children
- Initial Assessment: N-FOCUS
- Initial Assessment: N-FOCUS Assessment
- Engaging Families: Initial Safety and Risk Assessment Application
- Developmental and Behavioral Challenges and Concerns (0-5 yrs.)
- Critical Thinking in Case Analysis

### **Status Update: *Complete***

DHHS reports that CCFL has updated its New Worker Training to include a more intensive focus on family engagement. Additionally, in-service training for current CFS caseworkers assigned to initial assessment has been offered including Enhanced SDM Safety Planning, Engaging Families on Sensitive Subjects, and Engaging Families in Safety and Risk Assessments.

## **4. Further define process for utilizing child advocacy centers by Initial Assessment.**

Neb. Rev. Stat. §28-728 outlines when interviews of children are required to be conducted at a child advocacy center. DHHS Administrative Memo #21-2015 further outlines procedures of flagging cases at intake and when CAC utilization is required. The OIG recommends that DHHS further define and give direction to Initial Assessment regarding when a child advocacy center *should* or *may* be engaged and utilized in cases that present hard to interview children such as, but not limited to those with:

- Medical or psychological conditions,
- Developmental delays,
- Speech impairments, and
- Other situations where the child's uniqueness does not lend to a successful "regular" law enforcement-type or Initial Assessment interview.

### **Agency Response: Accept**

DHHS accepts this recommendation and will explore a revision to Administrative Memo #21-2015 to include further direction to Initial Assessment and On-going Case managers on when a CAC *could* or *should* be utilized and will take into consideration the child characteristics. DHHS will also assess the CAC's level of interest with collaborating on this specific recommendation.

### **Status Update: No Further Action**

**OIG Comment:** DHHS is no longer planning on revising Administrative Memo #21-2015. The decision to refer specific cases to CACs will be left to local 1184 or multidisciplinary teams. This decision was made to avoid placing the burden on DHHS staff alone for referral to a CAC. Additionally, DHHS believes many rural CACs do not have forensic interviewers with special training to deal with many of the special cases contained in the OIG recommendation. The OIG expects no further action regarding this recommendation.

## **5. Update and provide additional detail on response priority definitions.**

In this case, the Hotline made a number of errors in determining priority response time. Hotline workers and supervisors failed to identify the “child victim under 6 with an injury to the head or torso,” which is a required Priority 1 response. Some of these allegations also should have qualified for a Priority 1 response under the category, “injury requiring medical attention.” The OIG’s interviews with Hotline staff and supervisors did not produce any clear answers as to why this occurred. In order to gain insight into how frequent errors in priority response time were, the OIG reviewed all 110 accepted intakes alleging physical abuse of children under age 6 in May 2015. The OIG disagreed with DHHS screening only in 8.2 percent of cases (nine of 110 reports). However, a review showed that discretionary overrides were used in an additional 5.5 percent of cases (six reports). Most of the reports where the OIG believes there was an error or where discretionary overrides were used should have been Priority 1 due to an injury to the head or torso or an injury requiring medical attention. While the numbers of reports with overrides or disagreement are relatively small, given the severity of the allegations involved, errors that slow response time in Priority 1 situations can have severe consequences.

Upon review of the SDM Intake Screening Policy and Procedures Manual, the OIG believes that further clarification to the response priority definitions could be helpful in reducing errors or overrides. Injury to head or torso does not currently give specifics on whether the injury must be a current one and what is meant by an injury. In cases where the OIG believes the Hotline made an error or where discretionary overrides were used, the report often contained descriptions of more minor injuries, including small bruises, marks, or scratches. There also seems to be inconsistency in what parts of the body are included in the head and torso. In this case, and the OIG review of recent intakes, injuries on or around the eye seemed to be one of the more likely locations to be looked over for a Priority 1 response time. Injuries to the back and shoulder (which links the torso and the arms) were also assigned lower Priority Response times. Additional clarification could be helpful in producing a more accurate and uniform screening as well as reducing the use of overrides. There may be additional clarifications to the definitions that would

be helpful, and the OIG recommends DHHS work with Hotline staff and supervisors to make any needed revisions.

**Agency Response: Accept**

DHHS accepts this recommendation and is currently in the process of reviewing the SDM Intake Screening Policy and Procedure Manual. A team of central office, intake, Initial Assessment and on-going case management staff are in process of reviewing and providing recommendations to the SDM Intake Screening Policy and Procedure Manual. This team will review the response priority definitions as a part of their review. Regarding further definition of the "head and torso," regions of the body, DHHS will reach out to Dr. Suzanne Haney for consultation on these specific definitions as well as explore the feasibility of having Haney review and provide feedback to DHHS on the entire SDM Intake and Screening Policy and Procedure Manual.

Decisions regarding the assignment of the most appropriate priority response are included in Quality Assurance Reviews, see item 12 below for May 2015 data that included a review of 183 randomly selected intakes (80 were accepted reports). The Quality Assurance Review agreed with the priority response assignment 97.5 percent of the time. The Quality Assurance team is currently in the process of reading 200 intakes for the current quarter.

**Status Update: *Incomplete***

DHHS is in the process of identifying areas where improvements are needed based on staff and medical feedback. An updated SDM manual for the Hotline is expected to be issued by February 2017.

**6. Conduct an analysis to determine whether supervisory staffing at the Hotline is adequate.**

Currently the Hotline has only four supervisors who are responsible for reviewing screening decisions and priority response time on every intake, ideally within 24 hours. Data collected by DHHS on Hotline calls shows that the Hotline received anywhere from 5,811 to 7,075 calls a month between May 2014 and April 2015. This means each supervisor is responsible for reviewing and catching any errors on an average of over 1,500 calls each month in addition to other duties. Given its current resources, the overall quality of intakes and screening decisions is impressive. However, the OIG has also noted a number of errors in this case and others that have contributed to delaying or preventing a response to situations where children were in jeopardy.

The OIG has serious questions about whether the current supervisory staffing level at the Hotline is adequate to ensure that no cases slip through the cracks. The OIG recommends that DHHS conduct an analysis to determine whether supervisory staffing is sufficient. Perhaps the current national consultant working on caseloads could assist DHHS in assessing the Hotline as well as Initial Assessment and ongoing caseloads. The OIG recommends that DHHS consider both increasing supervisory staffing and making other adjustments to continue to ensure that no cases where children's safety could be jeopardized fall through the cracks or are incorrectly screened.



**Agency Response: Accept**

DHHS offers the following alternative language pertaining to this particular recommendation: "Conduct an analysis of the current expectations regarding the Intake Supervisor's review of intakes." The concern identified by the OIG is related more to supervisor workload and expectations versus staffing levels. There are many different types of reports that do not need supervisory review or oversight, however, there are many types of reports that need more time and attention from Intake Supervisors. DHHS is in the process of evaluating the types of reports that need supervisor review and oversight and how best to provide immediate review and feedback to Intake (Hotline) staff. DHHS has also implemented a daily peer review of intakes accepted for Alternative Response. While the daily team review is very new, it appears to be an efficient way to review and provide quality feedback and support to the Intake staff.

**Status Update: *Progress***

DHHS has made some changes to supervisory workload at the Hotline. In fall 2015, supervisors began reducing the number of reports accepted for assessment they reviewed. They continued to review all screened out reports. New supervisory workload guidelines at the hotline are expected to go into effect in September 2016.

**7. Expand quality assurance and continuous quality improvement (CQI) at the Hotline.**

A meeting with the Hotline Administrator and Field Operations Administrator revealed that about 300 intakes to the Hotline each quarter are assessed by quality assurance staff and included in Continuous Quality Improvement (CQI) data. This represents a tiny fraction of the calls (around 1 percent) that come into the Hotline. The OIG recommends that DHHS consider expanding and also revising quality assurance and CQI processes at the Hotline to make them as meaningful as possible and expand the number of intakes reviewed. The OIG recommends that priority response time be included in CQI data that is reviewed quarterly.

**Agency Response: Accept**

DHHS is committed to using quality assurance reviews and the CQI system as often as is possible in order to monitor and improve performance. Decisions regarding the type of quality assurance reviews and the frequency of these reviews must be planful and balanced between the workload and the priorities identified. This recommendation will be shared and discussed with the CFS Research, Planning and Evaluation Administrator for review and consideration.

**Status Update: *Incomplete***

In the fall of 2015, CQI staff began listening to randomly selected Hotline calls to provide further feedback to the Hotline. However, given other priorities there are no plans to expand the number of intakes reviewed or focus on any type of special cases.

# Investigation Summary:

## Death and Serious Injury Following a Child Maltreatment Investigation

Between June 2013 and June 2015, 11 Nebraska children who had recently been the subject of a child abuse or neglect investigation died or were seriously injured. In all of the cases, the injuries were caused by abuse or neglect.

Over the past fiscal year, the OIG prioritized investigating these cases individually, in addition to comparing them to identify trends and common issues that may be limiting the effectiveness of child abuse investigations, which are referred to as Initial Assessments by the state Department of Health and Human Services (DHHS).

This investigation summary contains background information on Initial Assessment, individual case summaries for each of the deaths or serious injuries, and findings on common themes from the cases as a whole.

### Background on Initial Assessment

Initial Assessment refers to the process of DHHS staff assessing families after a report of child abuse, neglect, or dependency has been accepted by the Child Abuse and Neglect Hotline as meeting the definition of child abuse or neglect.<sup>11</sup> Initial

Assessment is intended to ensure child safety, determine whether the alleged maltreatment actually occurred, and to decide whether to offer the family ongoing services.<sup>12</sup>

In 2012, DHHS adopted Structured Decision Making® (SDM), a nationally-recognized set of assessments and tools. Since then, SDM has been used to guide decisions on child safety, risk of future maltreatment, and whether an ongoing case should be opened.

Every year since 2012, DHHS has completed Initial Assessments on more than 12,000 reports of child abuse or neglect, involving an even greater number of children.<sup>13</sup> While each case of death or serious injury after an Initial

Assessment is troubling, it should be noted that these 11 cases represent only 0.02 percent of children involved in Initial Assessments from January 2013-June 2015.<sup>14</sup>

In Nebraska, other entities and agencies are often involved with children and families during the Initial Assessment process. State law specifies that the duties of receiving reports of child abuse and neglect and conducting the subsequent investigation are

shared between DHHS and law enforcement.<sup>15</sup>

Nebraska law further requires that each county attorney convene multidisciplinary investigative

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***Initial Assessment refers to the process of DHHS staff assessing families after a report of child abuse, neglect, or dependency has been accepted by the Child Abuse and Neglect Hotline as meeting the definition of child abuse or neglect.***

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teams (also called “1184 teams”) in their area. These teams include the local child advocacy center, DHHS, and law enforcement and establish protocols for joint investigations and coordination on child abuse and neglect reports.<sup>16</sup>

DHHS staff are charged with conducting the Initial Assessment adhering to DHHS rules, regulations, and program guidance memos on their own process, while still cooperating with law enforcement directives and the procedures of the local 1184 teams.

Through its interviews with staff across the state, the OIG learned that variation in local practices and policies leads to a range of Initial Assessment practice by DHHS.

For example, in some areas law enforcement rarely responds to child abuse or neglect reports with DHHS, while in other areas law enforcement officers accompany DHHS on every single Initial Assessment. In practice, Initial Assessment varies not only between DHHS Service Areas, but between individual offices or even communities within those Service Areas.

## Summary of cases included in report

The 11 cases – two deaths and nine serious injuries – included in this report came to the OIG’s attention through Critical Incident Reports received between July 2013 and June 2015 by DHHS’ Division of Children and Family Services (CFS).

The OIG focused the report on cases where no ongoing services had been provided to the child or family by CFS. Cases where the cause of death or serious injury was not related to abuse or neglect were also excluded from this report. Table I. gives basic information on all the children included in the report. Cases included came from every CFS Service Area, except the Eastern Service Area (Douglas and Sarpy counties). A map showing the CFS Service Areas can be found in Appendix C of the report.

**Table I. Cases Included in Report**

TYPE OF INJURY	AGE AT INJURY	SERVICE AREA
<b>Near Drowning</b>	15 months	Southeast Service Area
<b>Collapsed Lung, Multiple Fractures</b>	3 years	Southeast Service Area
<b>Skull Fracture</b>	8 months	Southeast Service Area
<b>Abusive Head Trauma</b>	6 months	Southeast Service Area
<b>Abusive Head Trauma</b>	16 months	Central Service Area

<b>Battered Child Syndrome, including Abusive Head Trauma</b>	3 years	Western Service Area
<b>Death - Abusive Head Trauma</b>	8 months	Central Service Area
<b>Abusive Head Trauma</b>	2 months	Northern Service Area
<b>Starvation</b>	3 months	Southeast Service Area
<b>Skull Fracture</b>	3 months	Southeast Service Area
<b>Death - Drowning</b>	2 years	Southeast Service Area

## Individual Case Summaries

### Death of 8-month-old in Central Service Area

An 8-month-old was flown to Children’s Hospital in Omaha after being found unresponsive while in the care of his 26-year-old father. The child died two days later due to a subdural hematoma, retinal hemorrhage, and lacerated liver. In addition, he had several broken bones. The father pled guilty to causing his son’s death.

**Prior DHHS Involvement:**

Six months before his death, DHHS received five reports at the Hotline alleging that the infant or his older sister were receiving inadequate care, both medical and emotional, from their mother, who was suffering from significant depression. Between the time the initial report was accepted and the DHHS caseworker made contact with the family, the child’s mother was so overwhelmed she made arrangements for her son to live with his babysitter. The DHHS caseworker helped the mother give power of attorney for her son to the babysitter, who only a month later sent the child to live with his father.

**Issues identified:**

1. The 10-day response of the worker met policy, but was too long to assess urgent family needs called into Hotline between the first accepted report and safety assessment.
2. Safety Assessment did not appropriately identify the SDM Safety Threat #7 – “Caregiver is unwilling to provide care.”
3. DHHS did not follow established policy because the infant was placed with his babysitter through a power of attorney agreement, instead of creating a safety plan and following the procedure for a voluntary placement agreement or informal living arrangement.
4. Not all required collateral contacts were made during the Initial Assessment, including non-custodial parents and medical professionals. Written documentation from law enforcement was not entered into case file.

5. The caseworker completing the Initial Assessment was experienced, but had a pattern of cutting corners and working outside DHHS policy. Long-distance supervision made this difficult to manage.

### Death of 2-year-old in Southeast Service Area

A 2-year-old drowned in the family's pool. Although the child's mother, mother's boyfriend, and grandmother were home, no one was supervising the child outside for a number of hours.

#### Prior DHHS Involvement:

The child's mother and grandmother had long histories with CFS and other community services. The mother, diagnosed with developmental disabilities and bipolar disorder, had relinquished rights to an older sibling before the child's birth. After the child's birth, three intakes were accepted due to inappropriate caregiving, unsanitary conditions, and domestic violence between the adults in the household. Although the family scored as high risk during an Initial Assessment six months before the child's death, no case was opened since other agencies were offering services to the family. Two weeks before the child's death, the Hotline received and screened out a call from a service provider related to inappropriate supervision of children and domestic violence.

#### Issues Identified:

1. The Hotline failed to make a required collateral call before screening out the child neglect report made before the child's death. The collateral call was required by policy, since the mother had a prior relinquishment.
2. The case closed although family was high risk, meaning they qualified for services. Although the family was receiving other services, these service providers were the ones who called the Hotline to request CFS intervention.
3. Not all required interviews and contacts occurred. The mother's boyfriends were not interviewed or included on the assessments, although reporters to the Hotline, including the developmental disabilities service coordinator, indicated that they were living in the home.
4. The rural location limited the number and types of services available to the family.

### Serious Injury of 3-year-old in Southeast Service Area

A 3-year-old was run over by her father's truck. The child and brother had been left unattended in the running vehicle while the father was inside a gas station. The child got out, fell, then the vehicle rolled over her resulting in a collapsed lung, a broken clavicle, and a number of other injuries.

### Prior DHHS Involvement:

Eleven months before the serious injury, the child's mother was cited by the police for improper supervision of the child and her brother, who was 3 at the time. The case was closed after the children were found safe and the risk for future maltreatment was moderate. Four days before the serious injury, police responded to a call about the child left wandering naked and unattended in the street. The police forwarded the report to the Hotline two days later, however CFS had not made contact with the family when the injury occurred.

### Issues Identified:

1. The time lag between police contact with the family and reports to the Hotline, delayed CFS' contact with the family.
2. The Hotline report received just before the serious injury was assigned the wrong response time, delaying contact with the family.
3. Contact was not made with the non-custodial father during the Initial Assessment although it was identified that he lived in the same building.

## Serious Injury of 1-year old in Southeast Service Area

A 15-month-old was found unconscious in the bathtub of the family home by the mother, who had been napping on the couch. The child's 3-year-old sister woke her mother up to tell her the child was blue. The older sibling told police that she put water in the tub and put her younger sibling in. Police officers, who were already in the neighborhood, arrived within a couple of minutes of the 911 call, began CPR and successfully revived the child, who was then taken to the intensive care unit at the local hospital. Responding officers reported that the home was extremely cluttered and unsanitary. They also found drug paraphernalia.

### Prior DHHS Involvement:

Two allegations of physical neglect of children in the family were investigated 10 and 11 months before the serious injury. In the first incident, officers responded to a call that the then-2-year-old sister was wandering in the street unaccompanied. The parents were cited by law enforcement. Their report was also sent to DHHS, which found the children safe. Although the family was found to be high risk, they declined services and the case was closed. The next month, an identical allegation of the 2-year-old being left unattended was accepted. The children were found safe, but the family again scored as high risk. DHHS scheduled a meeting to discuss opening a voluntary case, however, the family moved without telling DHHS and there was no way to track them.

### Issues Identified:

1. The family scored as high risk and had similar issues occurring, however, DHHS was not able to open a case.

## Serious Injury of 8-month-old in Southeast Service Area

An 8-month-old child was taken to a local hospital after repeated vomiting. He was admitted to the hospital with a skull fracture and then transported to Children's Hospital, where it was determined he had suffered a comminuted skull fracture (shattered skull) but no brain injury. It remains unclear how the injury took place and no charges have been filed in this case. Doctors believe that some force was required to produce the injury, but the perpetrator could either be the 9-year-old brother, who had behavioral concerns and was diagnosed with attention deficit hyperactivity disorder (ADHD), or the mother's boyfriend. Both were left in charge of the infant before to the onset of his symptoms.

### Prior DHHS Involvement:

In the six months prior the injury, there were four reports to the Hotline, three of which were accepted for Initial Assessment. Three months before the injury, DHHS assessed reports related to inappropriate supervision of the infant and his siblings by their mother. There were concerns that her boyfriend, who had a recent agency substantiated case of sexual exploitation of his two nephews, had substantial unsupervised contact with the children or that they were left unattended by both adults. The children were deemed conditionally safe and a safety plan was put in place to ensure the boyfriend was not left alone with the children. Although the case scored high risk, it was closed as the family declined services and police and the county attorney did not feel there was enough information to keep the case open. One month before the serious injury, the infant was hospitalized with a broken arm. During the investigation the brother admitted to stepping on the infant's arm while he was watching him. No safety threats were identified, and although the family scored as high risk, the case was closed as ongoing services were again declined.

### Issues Identified:

1. DHHS requested that the infant's siblings be interviewed at a child advocacy center as part of a sexual abuse investigation. Law enforcement and the county attorney refused to take action.
2. During the intake related to a broken arm, no documentation was found that CFS examined a possible safety threat related to
3. Collateral contacts to the children's non-custodial parents were not completed.
4. The case closed twice although family was considered high risk for ongoing maltreatment and reports continued.
- improper supervision by leaving the infant in a 9-year-old's care.

## Serious Injury of 6-month-old in Southeast Service Area

A 6-month-old was taken to the hospital after vomiting and having difficulty breathing shortly after being left alone in the care of his step-father. He was discovered to have multiple skull fractures, bleeding on the brain, and both old and new bone breaks to his arm. The step-father was found to have caused the injury.

### Prior DHHS Involvement:

Four months before the serious injury, police responded to a domestic assault report at the child's residence. Police took no action because the step-father left the home voluntarily. But they forwarded the report to the Hotline because the incident occurred when the child and his older sister were in the home. The report was accepted for an Initial Assessment. The family was found safe and the final risk score was moderate, which meant the case was closed with no offer of services.

### Issues Identified:

1. The Risk Assessment did not accurately score the husband's substance abuse. Although he told DHHS he had problems with excessive drinking, which often led to violence, no substance abuse issue was noted.
2. No collateral contact was made with those who could comment on domestic violence between the couple. Information from the investigation into the child's injury revealed that the grandmother and the neighbors in the apartment were aware of an escalating pattern of domestic violence even before police and DHHS became involved, but they were never contacted.
3. No referral for a substance abuse assessment or therapy was made for the husband during the Initial Assessment, although he indicated that he was trying to stop drinking.

## Serious Injury of 1-year-old in Central Service Area

While in the care of his non-custodial father, the 1-year-old child was transported to a hospital by ambulance with reported difficulty breathing. Hospital staff noted extreme bruising on the child's scrotum and head. The child was then flown to a different hospital where he was diagnosed with a skull fracture and brain bleed/brain damage. Older bruises were also found, indicating cigarette burns inside his mouth and hot liquid being poured down his throat. The father was found to have caused the child's injuries.

### Prior DHHS Involvement:

A month before the serious injury, the Hotline accepted a call from a hospital concerning bruising on the child's penis. Another service area completed a courtesy visit and safety assessment at the home of the child's grandmother. It was determined the child was safe since the mother said the injury was due to a bug bite. The worker assigned to the case conducted a follow-up visit to the mother's residence and found the family's risk was moderate. No ongoing services were offered and the case closed only 10 days before the serious injury. It was later determined that the non-custodial father also caused the bruising to the penis.

### Issues Identified:

1. A "priority response override" was incorrectly used to assign the call a slower response time, delaying the DHHS worker's contact with the family.



The override alleged that the child was in a safe environment while awaiting CFS response, however there was no information indicating that this was the case.

2. Lack of coordination with medical providers. No explanation for the injury was ever confirmed with the hospital that treated the child, nor was a medical opinion sought on whether a bug bite could have caused the bruising.
3. No photographs of the earlier injury were documented, due to a lack of coordination between DHHS, law enforcement, and the hospital.
4. The non-custodial father was never asked how the first injury occurred, although DHHS records indicate that the mother told them that he was present when she discovered her child's injury.

### Serious Injury of 3-year-old in Western Service Area

A grandmother was babysitting her granddaughter and noticed the child had not been eating, was running a fever, and was covered in bruises. She took the child to the hospital, where a subdural hemorrhage was found. The child was flown to Colorado Children's Hospital, where additional injuries, including a liver laceration, were discovered. Malnourishment was also discovered. The child was diagnosed with battered child syndrome. The mother's boyfriend is believed to have caused her injuries.

#### Prior DHHS Involvement:

Five months before the serious injury, the Hotline accepted a report alleging pattern bruising to the child's face and body. DHHS and local police responded to the call, but police declined to put the child in a 48-hour hold. The caseworker arranged for a doctor's appointment the next day. After the pediatrician told DHHS that the bruising was not caused by abuse, the child was deemed safe. The case was closed the next month, as the family scored as moderate risk and did not qualify for ongoing services. In the six months before the serious injury, DHHS and law enforcement also conducted two investigations into allegations that the mother's boyfriend physically abused his two sons during visitation with them. In both cases, the injured child's household was assessed for safety and risk. The last case was closed a month before the serious injury. Although the family was found to be high risk, the case was closed when they declined services.

#### Issues Identified:

1. A pediatrician did not correctly identify bruising caused by abuse. After the child's hospitalization, Colorado Children's Hospital stated that these earlier injuries were almost certainly due to abuse. A skeletal survey was requested but not followed up on by CFS.
2. No plausible explanation for bruising was given in April 2014, and excuses (anemia, the child naturally being small and weak) were not questioned.
3. Collateral contacts were limited. The child's grandmother (who had raised the child until recently) had concerns, but she was never contacted by DHHS.

4. One of the Initial Assessments did not follow required timelines and did not identify a number of concerning changes, including the child no longer attending daycare.
5. Concerns about injuries to the boyfriend's sons were dismissed as being related to a custody dispute.
6. The child's earlier injuries were never photographed by law enforcement or CFS.

### Serious Injury of 2-month-old in Northern Service Area

A 6-week-old child was taken to the hospital after his mother returned from work and noted he had difficulty breathing. Children's Hospital doctors found the child had suffered abusive head trauma and had significant brain injury, subdural hematomas on both sides of his brain, and retinal hemorrhages. He experienced a number of seizures while at the hospital, but survived. The investigation indicates that one of the parents was responsible, as no other caregivers had been watching the child.

#### Prior DHHS Involvement:

Shortly after the child and the child's twin brother were born, DHHS accepted a report that alleged erratic behavior and possible drug use by the children's father and limited preparation by the family for the babies. DHHS and local law enforcement responded to the report and found the children safe. A month before the serious injury, the case was closed after the risk was determined to be moderate. The family was referred to home visiting services.

#### Issues Identified:

1. Both parents tested positive for drugs during the Initial Assessment – the mother for THC and the father for THC and benzodiazepines, but little follow up was done.
2. The father's role as a caregiver while the mother was at work and his risk factors, including mental health, erratic behavior, and criminal history, were not assessed.
3. Limited collaterals were conducted. When family did not return calls, no follow up was done.
4. Investigation into the serious injury by local law enforcement was lacking. No reports or documents were ever made available to DHHS or the OIG. Little was done to question witnesses, secure the scene of the child's injury, or gather evidence.

### Serious Injury of 3-month-old in Southeast Service Area

The child was taken to a hospital with a low temperature and breathing problems. Doctors noticed severe diaper rash and a rash on the child's face. Shortly after, he was flown to Children's Hospital in Omaha, where doctors found the infant was near starvation. The infant likely suffered permanent brain damage from severe and persistent neglect on the part of his parents.

### Prior DHHS Involvement:

The child's family had a long history of being reported to child protective services due to marginal living conditions and chronic neglect. A day after the child's premature birth, a report was accepted alleging their older brother and other children in the multi-generational house were not properly cared for by the adults in the house and had unsafe living conditions. The family did not cooperate with the investigation, including not allowing DHHS to come into the home, and law enforcement declined to take action. The case was closed as high risk two months before the child was hospitalized. Just a week after the case closed, the Hotline received a call noting the child's mother was admitted to a psychiatric center after a suicide attempt related to depression. The hospital also called to report that the mother had scabies and was concerned about the conditions of the children in her home, but the call was screened out.

### Issues Identified:

1. During the Initial Assessment, contact was never made with the child, child's mother, or father.
2. The Hotline failed to make a required collateral call related to the intake on the suicide attempt and also failed to tie the infant to the intake.
3. Law enforcement and the county attorney declined to take action to allow
4. The infant's doctor was contacted by CFS to let him know about concerns and asked him to report any future issues, especially since the baby was premature, however he did not call the Hotline, despite the infant not coming in for medical appointments.

## Serious Injury of 3-month-old in Southeast Service Area

The child was taken to the hospital due to noticeable swelling of the head. The hospital discharged the infant with instructions to follow up with their primary care provider. The next day, the primary care provider recommended the infant be taken to Children's Hospital. Upon admission, a CT and skeletal scan revealed that the baby had a skull fracture in addition to a rash on the infant's neck. No explanation of the fracture was provided, and doctors agreed that it was likely not accidental. The criminal investigation remains open and the perpetrator is unknown, although the mother's boyfriend is a suspect. He was discharged a few days before the child's injury after serving a sentence related to domestic violence.

### Prior DHHS Involvement:

A few days after the child's birth, a call to the Hotline alleged that the mother had been using drugs and was not prepared to care for her baby. An on-call worker determined the child was safe within 24 hours. During the period of Initial Assessment, two additional calls to the Hotline were made by professional social service providers and medical staff, who raised concerns about the mother's ability to provide for her child's needs, including adequate clothing for cold weather. The risk assessment, finalized two months before the injury, found the case was high risk due to the mother's history with CFS as a state ward, as well as a history of recent domestic violence, but the case closed as the mother did not want

services. A few weeks before the injury, the Hotline screened out calls reporting concerns about the mother's boyfriend being released from jail and the infant being left with inappropriate caregivers.

### Issues Identified:

1. Collateral contacts were limited during the Initial Assessment period. No contact was made with the child's alleged father.
2. The caseworker did not have enough knowledge of infant development to identify the mother's lack of knowledge and concerning choices, including harmful attempts to force the infant to make bowel movements.
3. The case was closed despite high risk and indications that the mother needed additional parenting knowledge and support related to domestic violence in her relationship.

## Findings

### *Children age 3 and under were the victims in every case reviewed.*

Although they represented less than one third of all children involved in Initial Assessments from January 2013-June 2015, children aged 3 and under accounted for *all* of the cases of death and serious injury in this report.

Children under age 4 are the most vulnerable to child maltreatment fatalities nationally.<sup>17</sup> However, the OIG found specific challenges that staff face in completing accurate and thorough Initial Assessments when very young children are involved. Very young children are not able to communicate well enough to clearly disclose abuse or neglect. They are also much less visible in the community than school-aged children, especially if they do not have a child-care provider. Staff are often limited in the number of typical sources or collateral contacts who know the child well. It requires more effort to obtain even basic information when a young child is the alleged victim.

### *Physical abuse, most often abusive head trauma by the father or mother's male partner, was the cause of injury in the majority of cases.*

In seven of the 11 cases investigated, the OIG found that physical abuse was the primary cause of children's injuries. Five of the injuries involved a confirmed form of pediatric abusive head trauma, "an injury to the skull or intracranial contents of an infant or young child (less than 5 years old) due to inflicted blunt impact and/or violent shaking."<sup>18</sup> The frequency of abusive head trauma among the cases investigated by the OIG indicates that there is an opportunity to provide additional preventative information and support to families with young children, especially those who have contact with CFS).

Four of the seven cases of physical abuse within this report were caused by a male parent or caretaker. In the remaining three cases, the perpetrator remains unknown. The OIG investigation indicates a strong likelihood that the father or unrelated male partner was responsible, although no charges have been filed. This pattern of fathers or male partners at fault in physical abuse cases is consistent with national fatality data.<sup>19</sup>

In most cases of death or serious injury due to physical abuse investigated, the assessment of

the adult who caused the serious injury was limited during the CFS Initial Assessment. The framework of the Structured Decision Making® (SDM) Risk Assessment tool puts much more emphasis on the primary caregiver (almost always the mother) in determining risk of future maltreatment and whether a family should be offered ongoing services. Four of the cases involving later physical abuse scored as moderate risk and thus did not qualify for ongoing services during the prior Initial Assessment. In some of these cases, it was the father who caused the injury that had the most significant risk factors.

***Each family had significant risk factors for child maltreatment, but did not receive services.***

Six of the 11 families scored as high risk for future abuse or neglect on the SDM Risk Assessment, however no case received ongoing services. Most injuries in cases that closed as high risk occurred within 70 days -- about 2 1/2 months -- after the Initial Assessment closed.<sup>20</sup> Had a case been opened, CFS would have likely been providing services or had the opportunity to gather additional information before the injury. In most cases, families refused to participate in an ongoing case and CFS was not successful in engaging them in a voluntary case.

An OIG review of the five cases that scored as moderate risk, revealed that there were significant risk factors for abuse and neglect present. Some risk factors are not captured by the SDM Risk Assessment used by DHHS, especially secondary caregiver history (mental health and child maltreatment history) and parental age. The OIG also found that some cases scored moderate because insufficient information had been gathered or errors had been made in using the Risk Assessment tool.

***Most children lived in rural communities, impacting Initial Assessment practice and families' access to resources.***

The 11 cases reviewed as part of this investigation occurred in eight different communities across Nebraska, most of them rural. Two injuries occurred in counties where the largest city had a population of 10,000 to 50,000 people. Five injuries occurred in counties where all towns had a population of less than 10,000.<sup>21</sup>

National research shows that rates of child maltreatment are higher in rural areas.<sup>22</sup> While it is not entirely clear what accounts for the higher rate, rural communities tend to experience more persistent and intense poverty. Rural residents may be isolated, generally earn lower wages, have lower levels of education, and struggle with higher rates of substance abuse. Child welfare practice in rural areas is also complicated by travel time, the inability to have specialization among caseworkers due to low numbers, difficulty accessing services for families, and challenges with long-distance child welfare supervision.<sup>23</sup>

The rural location of families also impacted the availability of non-CFS services. In one case, developmental disability service providers would not go to a family home, as the area was too remote. Many families within cases investigated had difficulty accessing services for mental health or substance abuse issues because they were too far away.

***In nearly half of the cases, the Child Abuse and Neglect Hotline received an additional call between the Initial Assessment closing and the death or serious injury.***

The OIG found that in five cases, the Hotline received at least one report about the family or child after the Initial Assessment was closed, but before the death or serious injury. The reports occurred between two and 55 days before the death or serious injury. In a number of cases, errors were made in failing to make collateral calls, screening the report, or assigning a priority response time. In two cases, the time between the Hotline call and the required response was too long for DHHS to take effective action.

***Poor coordination or practice by other entities often impacted the outcome of the Initial Assessment.***

In every case the OIG investigated, law enforcement agencies, medical professionals, or both were involved in the Initial Assessment or investigative process. Poor practice by other agencies involved – poor coordination and miscommunication between DHHS and law enforcement or medical professionals – contributed to inaccurate information being gathered.

In a number of cases law enforcement declined to take action to gather key information – including photographing injuries, or getting a warrant to inspect a home or conduct interviews of children at a child advocacy center. In other cases, law enforcement delayed sharing reports with Child Abuse and Neglect Hotline, causing a delay in response.

Medical professionals did not accurately recognize or report child abuse in a number of cases. Incorrect information given to CFS caused a child to remain in a situation where they were

repeatedly physically abused for a number of months.

***Initial Assessment policy and procedure was not consistently followed.***

A consistent pattern across cases involving death and serious injury was the failure to follow DHHS policy regarding collateral information and documentation. Often cases were missing different pieces of required information, the general trend from the cases investigated was that important information was not gathered, not documented, or both.

Medical and law enforcement documents were often missing from the file. In some cases, not all adults in the household – or even alleged victims – were interviewed or observed. Non-custodial parents were rarely identified and contacted. This led to an incomplete understanding of the safety or risk of the families. Interviews with administrators, supervisors, and Initial Assessment CFS Specialists indicated that corners being cut during Initial Assessment was not rare, but fairly standard practice due to caseload and workload challenges.

***Initial Assessment and mixed caseloads do not comply with state law.***

Nebraska law requires DHHS to establish caseloads, “which provide for adequate, timely, and in-depth investigations,” and meet the workload standards established by the Child Welfare League of America (CWLA).<sup>24</sup> The CWLA caseload/workload standards adopted in 1999 specify that workers responsible for Initial

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***Administrators, supervisors, and caseworkers told the OIG that cutting corners during Initial Assessment was a fairly standard practice, due to caseload and workload challenges.***

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Assessment alone should only have 12 active cases in a month.<sup>25</sup>

Workers should receive no more than 12 *new* cases a month, and would likely receive a smaller number since some cases take longer than a month to close. Workers with mixed caseloads (both IA and ongoing) should have no more than four active investigations.<sup>26</sup> DHHS has also established a rural Initial Assessment standard of 10 active Initial Assessment investigations in a month, to help account for travel time.<sup>27</sup> More recent caseload recommendations from national entities are even lower. In 2015, the Annie E. Casey Foundation recommended that no more than eight to 10 new investigations be assigned to a worker in a month and that those with mixed caseloads should have no more than 10-12 cases all together.<sup>28</sup>

The OIG investigation found that DHHS is substantially out of compliance with Nebraska law and its own standards for Initial Assessment and mixed caseloads. The Southeast Service Area reported that its workers were each averaging three to five new Initial Assessments a week (up to 20 new investigations a month). The Western Service Area workers routinely received

12 to 14 new cases each month on top of what they already had. A number of workers interviewed reported that they had had more than 20 open investigations at least at one point in the past few years. While the DHHS Caseload report showed that 72 percent of Initial Assessment and 46 percent of combined initial assessment and ongoing workers had caseloads that were in compliance on June 30, 2015, this point-in-time measure likely underestimates the number of workers who have more cases than they should throughout the year.<sup>29</sup>

Throughout the course of the investigation, the CFS employees interviewed – from frontline staff to Central Office Administrators – identified caseload and workload as the primary obstacles to improving Initial Assessment practice and doing thorough work. A number of service area administrators admitted that corners tended to be cut when it came to gathering documentation, pushing to engage families, and conducting all required collateral contacts in cases that were perceived “as less serious.” The reason that supervisors and administrators seem to accept this routine level of non-adherence to policy is an acknowledgement that most staff simply have too many cases to fulfill all the requirements placed on them by Central Office.

## OIG Recommendations/Agency Response:

### 1. Increase the Initial Assessment workforce to comply with Nebraska law on caseload standards.

Throughout the investigation, high caseload and workload were consistently mentioned by staff across the state and at all levels -- from direct workers to administrators -- as the primary obstacle to improving Initial Assessments, making good decisions, and ensuring child safety. On July 12, 2016, DHHS data revealed that 1,144 Initial Assessments had not been completed within the required 30 days. High workload and caseload cause corners to be cut (including policy and timeframe requirements). This in turn contributes to bad, sometimes tragic, outcomes for children and families.

This investigation and publically available DHHS data indicate that DHHS is frequently out of compliance with state law on caseloads. DHHS administration has publically taken the position that it has enough

positions to meet caseload standards, assuming all positions are constantly filled. However, DHHS' calculation that indicates that it has enough workers does not appropriately account for a number of essential elements: sick, vacation, disability and holiday leave; the volume of Initial Assessments for months when intakes are particularly high; and mixed caseloads. Thus, the assertion that DHHS currently has enough positions to comply with Nebraska law is not accurate. The OIG recommends DHHS create additional CFS positions, accounting for the elements listed above, to ensure that it complies with Nebraska law on Initial Assessment and mixed caseloads.

**Agency Response: Accept**

CFS will continue to work with system partners to address caseload size standards and to identify reasonable options that allow CFS to address challenges associated with the Initial Assessment workforce capacity.

**Status Update: *Incomplete***

CFS is working towards increasing workforce stability by enhancing retention and filling vacancies in a timely manner. A number of non-case manager positions are being reviewed to explore whether repurposing of ancillary positions could be used as an option to improving compliance with caseload standards.

**OIG Comment:**

CFS will need to create additional positions to fulfill its caseload obligations under Nebraska law. However, little action to truly address caseloads has been taken to date. DHHS will continue to be out of compliance with Nebraska law and staff will continue to struggle to complete thorough, timely work to ensure children's safety.

**2. Take steps toward greater Initial Assessment workforce specialization and experience.**

The OIG recommends that DHHS develop a plan to move towards greater Initial Assessment workforce specialization and fewer mixed caseloads where possible. Administrators interviewed indicated that Initial Assessment requires specialized skills. Workers who enjoy and do well with ongoing cases often do not share the same characteristics and skills as Initial Assessment workers and vice versa. While most service areas try to have their workers focus more on either Initial Assessment or ongoing cases, most administrators indicated that moving towards greater specialization in workload, training, and supervision would be helpful. Most administrators and supervisors agreed that experience was especially important for quality Initial Assessment workers and suggested a different pay grade would be helpful to recruiting and retaining qualified and skilled workers.

**Agency Response: Accept**

In most areas of the state, Initial Assessment caseloads are specialized. In the most rural areas of the state, case managers may be conducting Initial Assessments as well as providing on-going case management to families.

**Status Update: *Incomplete***



DHHS indicates that it is working with service area administrators to identify strategies that promote Initial Assessment specialization when possible. DHHS Central Office indicated that the Initial Assessment workforce is already specialized in every Service Area, except Western. However, the OIG found that most Service Areas will give staff mixed caseloads to deal with workforce shortages, vacancies, or unexpectedly high numbers of cases or Initial Assessments. All Service Areas except Eastern commonly require Initial Assessment workers to work a few ongoing cases. Ongoing workers may also be asked to pick up a few Initial Assessments if there are shortages with Initial Assessment staff or a particularly high volume of new assessments.

### **3. Contract with an independent entity to perform a validation study of Nebraska's SDM Risk Assessment instrument.**

Half of the families who experienced a death or serious injury within twelve months of a closed Initial Assessment scored as moderate risk for future abuse or neglect. The OIG's investigation found a number of areas and risk factors for abuse and neglect that are not being captured in the current SDM Risk Assessment, especially related to secondary caregivers. Now that SDM has been in use in Nebraska since 2012, the OIG recommends that DHHS commission a validation or fit study of the SDM Risk Assessment to ensure that it is working as intended, identify any needed changes, and ensure services are targeting the right families and children. A number of other states using SDM have commissioned similar studies and made improvements to their SDM tool.<sup>30</sup>

#### **Agency Response: Accept**

A component of the CFS CQI program includes an analytical and quality review of SDM fidelity and usage. The studies continually performed include a variety of subjects including but not limited to: a. timeliness/presence of assessments, b. statistical analysis of safety, risk and needs scoring for each assessment across the state for consistency and comparative purposes, and c. qualitative review to determine if case information and narrative supports the SDM scores. Through these internal reviews we are able to determine fidelity with policy, which is based on the evidence based practice. Thus far, our analysis indicates that SDM adequately serves the intended purpose of assessing safety, risk and family strengths & needs while improving the case manager's ability to engage youth and family members. The challenge most frequently found in our analysis indicates the opportunity for improved execution of SDM assessments which correlates directly with worker experience/tenure and capacity. Later this spring, CFS will be working with consultants affiliated with Casey Family Programs and Dr. Raylene Freitag with the Children's Resource Center on a project focused on examining the use of SDM Safety and Risk Assessments and how SDM may be used to drive service selection decisions.

#### **Status Update: Progress**

DHHS indicates that the National Council on Crime and Delinquency will conduct a validation analysis on the SDM® Risk Assessment, beginning in October 2016.

#### 4. Gather and analyze additional data on the prevalence of pediatric abusive head trauma and update shaken baby syndrome materials distributed by the Division of Public Health.

The limited data that is available on the prevalence of pediatric abusive head trauma in Nebraska indicates that Nebraska children are more likely to die of this injury than the national average.<sup>31</sup> Based on this information and the prevalence of these injuries in the cases investigated, the OIG recommends that the Division of Public Health gather and analyze additional data on the children who receive medical treatment for abusive head trauma at least once a year. With more detailed data, Public Health will better be able to determine the incidence of these injuries, assess current prevention efforts, and develop additional targeted prevention efforts and monitor their success.

The OIG also recommends that DHHS update materials on shaken baby syndrome that are statutorily required to be viewed and read by parents of newborns in hospitals or other medical facilities ( Neb. Rev. Stat. §71-2103). The OIG recommends that DHHS assess whether it needs additional funds to update the materials and provide adequate support to and monitoring of medical facilities' participation in this prevention strategy. DHHS should also assess whether Nebraska law is consistent with current best practices on abusive head trauma prevention and recommend any needed changes to best promote effective prevention strategies.

##### **Agency Response: Accept**

CFS will continue to work with the Division of Public Health (DPH) to develop and enhance prevention efforts related to pediatric abusive head trauma. As recommended, CFS will work with DPH to update the materials on shaken baby syndrome that are statutorily required to be viewed and read by parents of newborns in hospitals. In addition, CFS plans to add a "Coping with Crying" public service announcement to the radio schedule aired by the Nebraska Broadcaster's Association. Finally, along with DPH, CFS is participating in the Intel-personal Violence (child abuse and neglect) strategy team for the Child Safety Collaborative Innovation & Improvement Network (CoIIN) that is led by the Children's Safety Network. Through the Child Safety CoIIN, states, territories, and tribal communities will work with one another and with a panel of injury and violence prevention advisors to increase the adoption of evidence-based policies, programs, and practices at the national, state, and local levels.

##### **Status Update: Progress**

The results from the "All Birthing Hospital Wide Safe Sleep and Shaken Baby Survey" collected by the Division of Public Health in April 2015 are also being reviewed. The "Coping with Crying" public service announcement will be added to the radio schedule aired by the Nebraska Broadcaster's Association in early 2017. The Abusive Head Trauma Prevention Tool Kit is scheduled to be completed by June 2017.

#### 5. Increase the capacity for the CFS workforce to participate in pediatric abusive head trauma prevention efforts.

The OIG's investigation also revealed that the CFS workforce is not adequately prepared to engage in abusive head trauma prevention when it assesses or works with families with infants or young children.

The OIG recommends that DHHS CFS ensure that staff are trained on abusive head trauma risk factors and prevention strategies. The OIG recommends that CFS Specialists provide information on preventing abusive head trauma anytime that it assesses or works with a family with an infant. This should include ensuring parents have a plan for what to do when children cry for prolonged periods.

**Agency Response: Accept**

In order to ensure that the CFS workforce is adequately prepared to engage in abusive head trauma prevention, CFS will explore on-going training opportunities for staff and provide staff with information to give to families on preventing abusive head trauma. CFS believes in the importance of giving parents and caregivers tools that can help them cope if they find themselves becoming frustrated while caring for a baby. Currently, the Initial Assessment staff in the Eastern Service Area distribute an “under 2 packet” to families with children under 2. The “under 2 packet” contains information on abusive head trauma prevention -- including resources, signs and symptoms. In partnership with DPH, CFS is reviewing the materials in the ESA “under 2” packet and creating a statewide packet for staff to distribute anytime they assess or work with a family with an infant. CFS plans to include information about the Period of Purple Crying as babies’ ages 2 to 4 months are particularly at risk of injury from shaking because of their size and they tend to cry more frequently and longer than older babies.

**Status Update: Complete**

CFS distributed an “under 2 packet” with information about pediatric abusive head trauma to field staff in April 2016. The packet was developed with DPH assistance and is available in English and Spanish. Staff were encouraged to give out the information anytime they assess or work with a family with a very young child.

## **6. Increase the number of supervisors at the Child Abuse and Neglect Hotline and assess Hotline workload and ongoing training and supervision.**

In previous reports of investigations, the OIG has suggested that DHHS closely examine whether there are enough supervisors at the Hotline to provide adequate oversight of intakes and CFS Specialists who respond to calls. Continuous Quality Improvement data on Hotline calls shows that the Hotline received between 5,877 and 7,258 calls each month during 2015. This means each supervisor is responsible for reviewing and catching any errors on an average of over 1,500 calls each month in addition to other duties.

As this report demonstrates, the OIG continues to come across errors and oversights at the Hotline which contribute to poor outcomes for children and families. Visits to the Hotline and interviews of the Hotline staff, supervisors, and administrators revealed that supervisors do not have enough time to provide proper oversight of all intakes or provide adequate supervision, ongoing training, and assistance to employees. Given the workload, errors and oversights are almost inevitable.

The OIG recommends that DHHS create additional supervisor positions at the Hotline. The OIG also recommends that DHHS assess whether the workload of CFS staff answering Hotline calls is manageable and whether ongoing supports (training, staff meetings, and supervisory feedback) provided to them are sufficient.

**Agency Response: Accept**

CFS will assess the number of supervisors and the responsibilities of the supervisors at the Child Abuse and Neglect Hotline as well as workloads, training and supervision.

**Status Update: *Incomplete***

New supervisory review expectations will go into effect at the hotline in September 2016. However, DHHS has no plans to increase the number of supervisors at this point.

**7. Enhance data available on Initial Assessment and mixed caseloads at Central Office and make this information publically available on a monthly basis.**

Through its investigation, the OIG learned that caseload data on an ongoing basis is tracked and reviewed almost exclusively by individual service areas. Furthermore, most service areas do not track Initial Assessment caseloads according to CWLA standards, which cap the total number of investigations completed in a month. Instead, most service areas rely on a point-in-time measure on a weekly basis, while other service areas capture data less frequently.

The OIG recommends that Central Office enhance its capacity to review, track, and analyze Initial Assessment and mixed caseload data to ensure there is consistent statewide data available. The OIG also recommends that DHHS make information on caseloads of CFS Specialists available to the public on a monthly basis to ensure that the law is met across Nebraska.

**Agency Response: Accept**

The CFS Quality Assurance team is currently testing a new caseload/workload methodology for case assignments. CFS also provides the Legislature with an annual point-in-time report that illustrates caseload sizes based on the CWLA guidance.

**Status Update: *Incomplete***

**OIG Comment:** The OIG believes that reporting on caseloads once a year is insufficient. Reporting on caseload sizes for a single day each year does not offer a comprehensive view of the caseload challenges faced by CFS. The OIG continues to encourage CFS to put together the point-in-time CWLA caseload compliance data at least monthly and make it publically available.

**8. Collect data on high and very-high risk cases that do not accept services and implement more promising approaches to family engagement.**

Half of the families who experienced a death or serious injury within a year of a closed Initial Assessment scored as high risk for future abuse or neglect. Although this qualified them for ongoing services, the families declined services and no ongoing case was opened. A crucial opportunity to prevent a poor outcome in each of these cases was lost.

The OIG recommends that DHHS collect and analyze data on cases that score as high or very- high risk but do not have ongoing cases open on a routine basis. This will allow DHHS to better understand what barriers exist to providing services to families who qualify and better target specific types of children and families or specific areas of the state where engaging families in services is particularly difficult.

Data provided to the OIG by DHHS shows that from January - June 2015, 811 children age 3 and under were involved in an Initial Assessment that scored high or very high risk, but had no ongoing case opened. The number of children overall was significantly greater.<sup>32</sup> This suggests that more could be done to effectively engage families and offer services.

The OIG also recommends that DHHS develops and implements promising approaches to family engagement to see what works and expand those approaches accordingly.

**Agency Response: Accept**

The CFS CQI team does collect data and conduct analysis on those families who have been assessed as high and very-high risk per SDM, and who have chosen to not participate in services. For these specific cases, the analytics and data in N-FOCUS is insufficient to determine if improved case manager engagement would have made a difference with service participation. CFS will continue to explore other options using data to learn more about these cases and better assess case manager engagement.

**Status Update: *Incomplete***

CFS is in the process of developing a new data report that is projected to be ready in 2017 that collects and stratifies data on families determined to be high or very high risk by SDM.

**9. Restructure the Children’s Justice Act (CJA) taskforce to ensure there is a working group focused on improving child abuse investigations, especially multidisciplinary investigations. Enhance monitoring on how CJA funds are spent to ensure they are addressing systemic gaps in child abuse investigations.**

Through the CJA, Nebraska receives more than \$130,000 annually in grants from the federal government to make improvements to assessments and investigations of child abuse and neglect.<sup>33</sup>

Part of the funding requirement is the establishment of a CJA taskforce to comprehensively review and evaluate the handling of investigative, administrative, and civil and criminal judicial handling of child abuse and neglect. The taskforce is also charged with making policy and training recommendations to address deficiencies in a number of specific categories.

Currently, the Nebraska Commission on the Protection of Children (Governor’s Commission) is designated as Nebraska’s CJA taskforce. The Governor’s Commission also serves as a Citizen Review Panel among a number of other responsibilities and areas of work. It meets quarterly and all members are appointed by the Governor. While the taskforce gives DHHS recommendations on funding, DHHS personnel make final decisions on how federal dollars are allocated.

In 2013, DHHS contemplated creating a CJA taskforce separate from the Governor's Commission. This was due to a perception that the Governor's Commission could not comprehensively fulfill the CJA requirements and ensure that reviews focused on the many other issues it had taken on were consistently occurring.<sup>34</sup> However, the OIG learned that the plan to create a separate CJA taskforce was abandoned due to assurances from the Governor's Commission that it could fulfill all of its charges as well as what DHHS staff termed "political considerations."

In this investigation, the OIG identified a number of shortcomings in Nebraska's child abuse and neglect investigations, especially multidisciplinary investigations involving law enforcement and medical providers in rural areas. Long term system improvements in multidisciplinary investigations will require a range of stakeholder input and assistance to identify and implement needed improvements.

After its review of meeting materials and the current CJA three-year plan, as well as the discussions for the three-year plan due to the federal government later in 2016, the OIG believes that the CJA taskforce should be restructured to incorporate or consist of a working group that meets more frequently and focuses on improving child abuse and neglect investigation and prosecution in Nebraska. The OIG does not have an opinion on whether this group should be separate from or attached to the Governor's Commission. Whatever its structure, the OIG recommends that DHHS ensure that the taskforce is producing thorough, useable work with input from experts in a number of fields on a consistent basis.

Finally, the OIG recommends that DHHS increase its monitoring of CJA grant funds to ensure that they are being used to address the most pressing challenges with child abuse and neglect investigations. Currently, DHHS has limited monitoring of the funds and it is not clear whether sponsored training programs are having their desired effect or reaching the audiences and areas of the state most in need.

#### **Agency Response: Accept**

Since 1991 the Nebraska Commission for the Protection of Children has served as the state's CJA Task Force, which meets quarterly and provides an annual report. The task force must also complete an assessment every three years that clearly outlines the review, evaluation, and recommendations in all the required areas of the federal Child Abuse Prevention and Treatment Act requirements related to CJA. The Division of Children and Family Services' CJA Liaison attends the quarterly meetings and has meetings or exchange emails at least every other month. Discussions regarding the three year assessment and ongoing work of the CJA Task Force occur during these contacts.

The past two years, the CJA Task Force researched families that have two or more reports not accepted for assessment. This began as a project isolated to Douglas and Sarpy Counties. It has since been expanded to include all service areas. The purpose was to determine if the reports were being appropriately screened out and if there were any indicators of future involvement with DHHS which could be used to enhance the intake process. The reviewers agreed with the intake decision 96 percent of the time. Despite this outcome, the Task Force has continued to focus on this issue but over the last two annual reports have stated they are not ready to make recommendations. The CJA Task Force identified concerns in their annual reports but made no recommendations for change or developed any subcommittees to do an in depth review for recommendations. They continue to request information

from a wide variety of areas to include the Court Improvement Project and the Nebraska Sex Trafficking Task Force to determine if the Commission should make recommendations to the Governor's Office.

CJA funds are used for a number of different activities that meet the federal requirement on how CJA funding can be used. Funds support the multidisciplinary teams, Court Appointed Special Advocates (CASA) and multiple trainings throughout the year. The funds are also used to compensate Task Force member's travel and cost to attend meetings (food, parking, hotel if necessary and attending the annual conferences). Attendance at the annual conference is required by the CJA Liaison and one or more members of the CJA Task Force. The Division of Children and Family Services (CFS) will be contractually requiring the child advocacy centers to an expense reimbursement process in the next contract cycle. CFS currently issues a designated amount to the centers but do not have detail on billings of how CJA money is spent. CFS is developing a process to improve the monitoring of how CJA money is spent.

The Commission serves a dual role as the CJA State Task Force and as a Citizen Review Panel. Both of these roles involve reviewing policies and procedures of DHHS and making recommendations for change to improve the process for intake and Initial Assessment and evaluating information related to pilot projects, such as Alternative Response. This could also include the review of court processes and making recommendations that would be helpful to families involved with the courts. During the legislative session, they review pending bills and make recommendations when the Task Force agrees that a bill should be supported. All of this fulfills the requirements laid out in the Child Abuse Prevention and Treatment Act and CJA.

**Status Update: *Progress***

DHHS reports they are currently working with the Governor's Commission to formalize the topic that will be reviewed by its Citizen Review Panel. DHHS is also developing a process to improve monitoring of CJA funds.

**OIG Comment:** The OIG believes that ongoing multidisciplinary evaluation of how child abuse and neglect investigations and assessments are occurring is essential to keeping Nebraska's children and families safe. The Governor's Commission chairs have indicated to the OIG that they plan to create a separate working group to work on improvements to multidisciplinary teams. This is a good first step, and the OIG is hopeful that helpful recommendations for system improvement can be produced in a timely manner.

## Recommendations for Child Welfare System Improvement

Throughout its investigation, the OIG learned that child abuse investigation practice differs greatly across Nebraska, in large part due to the different practices and levels of training and knowledge of other entities that participate in child abuse and neglect investigations. If Nebraska is to improve its ability to appropriately investigate allegations of child maltreatment, more attention must be paid to the actions and abilities of entities outside of DHHS. The OIG believes that adopting the following recommendations for the child welfare system as a whole will better ensure that investigations are thorough, well-coordinated, helpful to children and families, and effectively prosecuted when appropriate.

*Conduct a statewide assessment of the 1184 teams*

There is a great need across the state for effective coordination between local entities involved in child abuse and neglect investigations. The 1184 teams were established by state law in 1992 to fulfill this function. Unfortunately, as the OIG's investigations of child serious injury and death revealed, there are still large gaps in coordination. The OIG also learned that across the state the 1184 teams vary widely in the protocols that they have adopted, the frequency of their meetings, what their main functions are, and who is represented. Interviews during the OIG's investigation indicated that while some investigative 1184 teams are considered extremely helpful, others are seen as completely dysfunctional. In some locations across the state, interviews indicated that teams are not meeting at all.

The OIG recommends that the state conduct a comprehensive assessment to better understand how investigative 1184 teams are functioning in different locations and to assess what policy changes may be necessary to ensure that high quality teams are functioning across the state and that best practices in child maltreatment investigations reach all Nebraska communities.

*Training and statewide standards for law enforcement related to child abuse and neglect*

Law enforcement entities across Nebraska have different levels of resources, training, and specialization related to child abuse and neglect investigations. They also have a wide variety of

practices and policies concerning how child maltreatment investigations are conducted.

The OIG recommends that Nebraska establish statewide standards for law enforcement related to child maltreatment investigations. The OIG also recommends an assessment of the current training and resources available on child abuse and neglect for law enforcement professionals across the state.

*Training and statewide standards for medical professionals related to child abuse and neglect*

Medical professionals across the state play a key role in recognizing and reporting possible child maltreatment. The differing levels of expertise and knowledge related to child abuse and neglect and how to effectively coordinate with DHHS and law enforcement among providers can mean that crucial signs of maltreatment or opportunities to intervene early are missed. The OIG recommends that Nebraska assess the availability of training and standards for medical professionals related to child abuse and neglect and determine what could be done to enhance the ability of medical providers to identify and treat child maltreatment.



# Investigation Summary:

## Sudden Unexpected Infant Deaths

Between May 2013 and December 2015, the OIG received seven reports of infants with prior or current child welfare involvement and four reports of infants in licensed child care centers dying suddenly and unexpectedly. The cause of death in these cases was usually not readily apparent. However, every death investigated occurred in an unsafe sleeping environment. These types of cases are often referred to as sudden unexpected infant death (SUID).

The infants in the report ranged in age from 18 days old to exactly 12 months; four cases were between two and three months of age, when Sudden Infant Death Syndrome (SIDS) risk is particularly high. The vast majority of cases in this report (nine of 11) were classified as SIDS, with one case of accidental suffocation and one case that was unknown. Eight of the 11 SUID cases occurred in Nebraska’s three most populous counties – Douglas, Sarpy, and Lancaster.

The OIG report highlighted the trends among the particular cases, the risk and contributing factors present in these cases, and an assessment of the current SUID prevention efforts by the Department of Health and Human Services (DHHS) focused on licensed child care facilities and families known to the child welfare system.

### Background on Sudden Unexpected Infant Death

There are approximately 3,500 sudden unexpected infant deaths each year in the United States, most often associated with an unsafe sleeping environment.<sup>35</sup>

Common factors that produce an unsafe sleep environment for infants include sleeping on their side or stomach (also called a prone position), sleeping with soft or loose bedding (blankets and pillows), and bed sharing.

The Centers for Disease Control and Prevention (CDC) groups SUID into three main categories:

- **Sudden Infant Death Syndrome (SIDS):** “sudden death of an infant less than 1 year of age that cannot be explained after a thorough investigation is conducted,

including a complete autopsy, examination of the death scene, and a review of the clinical history.” SIDS is the leading cause of death for infants less than 1 year of age;

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***SUID was the third leading cause of child death in Nebraska in 2010 and 2011.***

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- **Unknown Cause:** “sudden death of an infant less than 1 year of age that cannot be explained because a thorough investigation was not conducted and cause of death could not be determined.”; and

- **Accidental Suffocation and Strangulation in Bed (ASSB):** sudden death that may be caused by soft bedding covering an infant’s nose and mouth, a person rolling on top of or against the infant while sleeping, or an infant being wedged against or between objects.<sup>36</sup>

Since the release of the American Academy of Pediatrics safe sleep recommendations in 1992, the overall rate of SUID has declined significantly. However, the rate of ASSB has continued to rise since 1998, possibly due to more thorough death investigations.<sup>37</sup>

SUID was the third leading cause<sup>38</sup> of child death in Nebraska in 2010 and 2011. In those same years, the most recent for which a complete data is available, the Nebraska Child and Maternal Death Review Team determined nearly two-thirds of SUID cases were “somewhat preventable.” The team also noted, as in prior

years, that African-American infants were disproportionately represented.<sup>39</sup>

Data on infant deaths between 2010 and 2014 indicate there have been between approximately 20 and 25 SUID cases each year in Nebraska.<sup>40</sup> SIDS remains the most common type of SUID, followed by unknown cases and accidental suffocation or strangulation in bed respectively. The cases investigated by the OIG for this report included approximately 15 percent of the SUID cases in Nebraska in 2013 and 2014.

## Summaries of Cases Included in the Report

### *Deaths with Prior Child Welfare Involvement*

#### Death of infant girl - 5 months, 10 days

On the morning of the death, the girl’s grandmother awoke and discovered that the infant, who was sharing the bed with her, was not breathing. The baby was rushed to a hospital and pronounced dead on arrival. The autopsy conducted ruled the cause of the death SUID in association with bed sharing and the child’s diagnosis of Pierre-Robin Syndrome, a condition present from birth in which a small jaw makes breathing in infants more difficult.<sup>41</sup> The autopsy also noted that the baby was too small for her age (failure to thrive). At the time of her death, the child was part of a non-court child welfare case.

#### CFS Involvement before Death:

The Hotline received a report that the girl’s mother was consistently missing and rescheduling important medical appointments. The baby was born full term, but with a number of complicated medical disorders, including heart defects, rectal issues, and Pierre Robin syndrome. She had to be fed through a tube to her stomach and was on medications to prevent heart failure and fluid buildup in her lungs. The call was accepted for assessment by CFS. Although the child was found to be safe with her mother, an ongoing case was opened after the baby was hospitalized. Nebraska Families Collaborative (NFC), a contractor with DHHS, provided ongoing voluntary or non-court services to the mother and baby up until the time of her death. The services were meant to help with ensuring that the baby’s medical needs were met and that the mother had the resources and skills to care for her child.

### Risk Factors and Issues Identified:

- SUID Risk factors were present, including: bed sharing, environmental smoke, and possible overheating due to several layers of clothing.
- Throughout the non-court case, the mother continued to miss medical appointments and was not consistent in signing the mom up for recommended services. Despite these issues, NFC was planning to close the case.
- At the time of baby's death she was in the care of her maternal grandmother for the weekend. CFS records show that

the baby's mother was in need of appropriate respite care, however there is no record of this being put in place by NFC. Instead, the mother left the child with people who were not fully knowledgeable about her intense medical needs or may not have been fully appropriate. The grandmother had been in treatment for substance abuse -- and the baby's mother was a state ward for much of her childhood because her mother was not able to appropriately care for her.

### Death of infant boy - 5 months, 9 days

On the afternoon of the death, the girl's mother called 911 after waking from a nap to discover her 5-month-old son was not breathing. Medical staff arrived and pronounced him dead. The autopsy performed the next day ruled the cause of death as SIDS. Before his death, the boy had been sleeping in his car seat wrapped in a blanket. The boy, his mother, and her boyfriend had been staying in a motel room for about a week before his death, since they had no permanent housing. The motel room was extremely dirty, smelled heavily of smoke and was over 80 degrees, and a variety of prescription medications were found lying on the table. A non-court child welfare case involving the boy had closed less than two months before his death.

### CFS Involvement before Death:

The Hotline received two calls after the boy was born with benzodiazepines and opioids in his system, requiring that he be admitted to the neonatal intensive care unit. He was found conditionally safe and the family was found to be very high risk for future abuse and neglect, so an ongoing non-court case was opened. The mother and boy moved in with family, who supervised them consistently until the safety plan was modified to allow the mother to parent alone. CFS also worked to have the mother restart monthly appointments with a psychiatrist, who adjusted her medication. The mother and son moved back to her housing at a domestic violence shelter and the case closed.

### Risk Factors Identified:

- Unsafe sleep position in car seat;
- Overheating;
- Presence of environmental smoke;
- Presence of soft blankets and bedding; and,
- A medical history involving inadequate prenatal care.

## Death of infant girl - 4 months, 16 days

Police reports said the infant and her 1-year-old sister were put to bed about 9:30 p.m. Their mother reported checking on the girls between 2 a.m. and 3 a.m. The infant was sleeping alone in a bassinet next to her sister, who was in a separate crib. Both appeared fine. At 8:30 a.m., the girls' father went to check on them and found blankets covering the infant, who was unresponsive and not breathing. 911 was called and responders declared her dead. Police investigators said she was lying on her back when they arrived. There was also a baby bottle, a blanket, a doll, a "burp rag," and pillow in the bassinet. The autopsy listed the cause of death as SUID associated with unsafe sleeping habits.

### CFS Involvement before Death:

There was an unfounded Initial Assessment alleging possible domestic violence before the baby was born. Police investigated and issued no citations.

### Risk Factors Identified:

- Presence of soft bedding; and,
- Presence of a baby bottle.

## Death of infant boy - 2 months, 9 days

Police said the child's mother and boyfriend put the infant (who was born at 36 weeks via C-section and had no significant health problems) in his crib, swaddled in a blanket, about 1 a.m. They soon heard the baby crying, went to check on him and found him not breathing and blue in color. Police and rescue units were called and the baby was taken to a hospital and pronounced dead. The autopsy listed the cause of death as SUID associated with unsafe sleep. It said the baby was found face down in the Pack and Play with multiple blankets and other soft objects.

### CFS Involvement before death:

An intake call said the mother and her boyfriend were propping a bottle to feed the infant. The day before, the reporter heard a commotion coming from the apartment and was told by the mother that the boyfriend was drunk and throwing things. Police and CFS responded and learned that the infant was at his maternal aunt's home at the time. The mother denied that there was any domestic violence. The safety assessment said there was no evidence of a safety threat.

### Risk Factors Identified:

- Unsafe sleep position;
- Presence of soft blankets and bedding as well as soft objects; and,
- Presence of environmental marijuana smoke.

## Death of infant girl - 2 months, 15 days

A state ward was rushed to the hospital after she was found not breathing in her crib by her father's girlfriend. The infant had not been checked on since the night before. After 30 minutes of attempting to revive the girl, she was pronounced dead. The autopsy ruled the cause of death as undetermined and noted that she was well-nourished, but dirty. It also noted her clothing was wet and smelled of cleaning fluid.

When police and medical personnel responded, they found unsanitary conditions in the home, including mold in the baby's bassinet, curdled formula in her bottle, debris and broken glass, trash and human feces in a number of rooms. The three other children in the home were removed due to these conditions. Later all three children tested positive for methamphetamines. The girlfriend, the primary caretaker, admitted that she had been consistently using methamphetamines. She was charged with felony child neglect. The father pled guilty to a Class I Misdemeanor of child neglect.

### CFS Involvement before Death:

The baby's mother was involved in an ongoing child welfare case through the court system after being arrested for selling methamphetamine with her son in the vehicle. The son was a ward of the state and placed with his father and father's girlfriend. The mother was also living with the father and his girlfriend for part of the time before the baby's death and was involved in a relationship with both of them. After the baby and mother tested positive for amphetamines, the child was made a state ward and placed with her father and his girlfriend. NFC provided the case management and recommended that the case of the mother and the child be closed as it considered them safe with the father and his girlfriend, despite Hotline calls related to concerns of domestic violence.

### Risk Factors and Issues Identified:

- SUID Risk factors were present, including: soft blankets in the bed and prenatal exposure to methamphetamines, tobacco, soft bedding and mold growing in the bassinet.
- Drug use, poor conditions of the home, and neglect of the children went undetected by the ongoing worker.
- Household risk and safety assessments did not include the mother, even when she was staying with the baby's father and his girlfriend.
- The quality of the casework and thoroughness of the supervision in this case were lacking.

## Death of infant boy - 1 month, 6 days

The infant's mother had recently moved in with the paternal grandparents, because of concerns about domestic violence between her and her boyfriend. On the night of the death, the mother left the infant in the care of his grandmother so she could go out to a movie. The grandmother fed the boy and laid with him on the couch until the mother came home at about 10:45 pm. The grandmother went to bed and the mother fell asleep with the infant on the couch, but later got up and left him there while she went upstairs to get her phone and change clothes. She said she laid down on her bed and fell asleep. The grandfather awoke at 5 a.m., went into the living room and noticed that the baby -- who was lying on his left side on the couch while

propped up on a pillow with a blanket over him -- was not breathing. He picked up the child and ran upstairs, where the grandmother administered CPR. The infant was taken by ambulance to a hospital and pronounced dead. The autopsy listed the cause of death as SUID "associated with unsafe sleeping habits."

#### CFS Involvement before Death:

A Hotline call from a hospital expressed concern about possible domestic violence between the mother and her boyfriend, and the use of marijuana in the home. The baby and mother each tested positive for marijuana and the boyfriend was reportedly using her pain medications. On Oct. 28, 2015, the Hotline received a call alleging that the home where the mother-to-be, her mother and her 11-year-old sister were living was unsanitary. The report was accepted for assessment. The safety assessment found the 11-year-old safe, although the caseworker did have concerns for when the baby was born. Although the family was found to be at high risk of future abuse or neglect, they declined services and the case was closed.

#### Risk Factors Identified:

- Unsafe sleep position;
- Presence of soft blankets and bedding; and,
- Environmental marijuana smoke

### Death of infant girl - 18 days

The child's mother called 911 and reported that her 2-week-old baby was not breathing. Shortly after arriving at the hospital, the baby was pronounced dead. The mother reported that she was lying on her back with the baby on her chest and fell asleep. When she woke up, the child had shifted to her side and the baby was next to her. The autopsy found that the baby's cause of death was accidental asphyxia by suffocation, likely due to the mother rolling against her while sleeping. An Initial Assessment of the household was completed less than a month before her death.

#### CFS Involvement before Death:

The Hotline received a call alleging that the home where the mother-to-be, her 11-year-old sister and their mother were living was unsanitary. The report was accepted for assessment. The safety assessment deemed the mother-to-be safe, although the caseworker did have concerns for when her baby was born. Although the family was found to be at high risk of future abuse or neglect, they declined services and the case was closed. The mother-to-be also had a number of interactions with the child welfare system as a teenager. These interactions, including a brief stay in a group home, were due to alleged sexual abuse by her step-father and trips out-of-state with adult men with whom she had sexual relationships.

#### Risk Factors and Issues Identified:

- SUID Risk factors were present, including: bed sharing.
- The law enforcement investigation into the death was not thorough, limiting the information available on circumstances

that may have contributed to the child's death.

- Initial Assessment identified potential concerns for a newborn baby in the house.

However, there were no collaterals done with others (medical professionals, etc.) to ensure that the mother had the resources she needed to adequately care for the baby.

## *Deaths in Licensed Child Care Facilities*

### **Death of infant boy - 3 months, 21 days**

The infant's parents woke up at 4:45 a.m. and fed him eight ounces of formula before taking him at 7 a.m. to her mother's (the infant's grandmother) in-home daycare. The day-care provider reported holding the infant until he fell asleep in her arms about 9 a.m., at which point put him in a Pack 'n Play, the mattress of which had a single, fitted sheet, on his stomach with a pacifier in his mouth and a blanket over him from the waist down. She said she checked him at about 9:45 a.m., saw the pacifier was out of his mouth. When she touched him, he was cold and not breathing. She called 911, put him on the floor, and administered CPR. He was taken by ambulance to a hospital, where he was pronounced dead. The autopsy listed the cause of death as SUID "associated with prone position and pacifier in mouth." It said he was born at 37 weeks and had a history of acid reflux. After the death, DHHS issued a Licensing Agreement for six months in which the day-care operator agreed that: infants must be placed on their backs for sleeping and that no other objects be present; if blankets are used, this should be done per the protocols described above; to take SIDS training within 30 days.

#### **Risk Factors and Issues Identified:**

- SUID Risk Factors were present, including unsafe sleeping position, soft bedding and a pacifier.

### **Death of infant girl - 3 months, 5 days**

At about 7:30 a.m., a father took his two children to daycare. The daycare provider put the baby down for a nap in the prone position in a Pack and Play sometime around noon. She checked on the infant after feeding the other children lunch and found the baby unresponsive. She immediately called a neighbor -- a police officer -- who arrived at the daycare within a minute and began administering CPR and called 911. The child was taken by ambulance to a hospital, where she was pronounced dead. The autopsy noted the presence of "mild patchy bilateral inflammation" on the lungs. "The degree of inflammation would not ordinarily be considered severe enough to result in death, but is significant and may have contributed." The cause of death was SUID associated with prone position in Pack and Play. DHHS moved to revoke the daycare license after finding the provider was neglectful in connection with the death by offering differing accounts of how the infant was placed in the crib and addressing questions about a possible defect in the Pack and Play mattress. The provider voluntarily surrendered her license.

#### Risk Factors and Issues Identified:

- SUID Risk Factors were present, including unsafe sleeping position.

### Death of infant boy – 12 months

The boy's father awakened his son about 6:30 a.m. and brought him to his wife so she could feed and dress him. The mother dropped the boy off at his daycare at 7:30. She said he was acting normally. The daycare provider said he was put down for a nap in a Pack and Play about 11 a.m. and found unresponsive about 1 p.m. She called 911 and began CPR. The boy was taken by ambulance to a hospital, where he was pronounced dead. The autopsy classified the death as SUID, but said it could possibly qualify as SIDS except for the child's age.

#### Risk Factors and Issues Identified:

- SUID Risk Factors were present, including soft bedding.

### Death of infant boy - 5 months, 16 days

The boy's childcare provider went to check on the boy during his afternoon nap and found he had rolled onto his stomach, was not breathing, and had a blanket up around his face. She had placed the child on his back with a blanket underneath him. Emergency personnel responded, initiated CPR, and rushed him to hospital, where he was pronounced dead shortly after arrival. The autopsy determined the cause of death was SUID associated with unsafe sleep, including his prone position and the loose bedding present, as well as the boy's recent cold.

#### Risk Factors and Issues Identified:

- SUID Risk factors were present, including: soft bedding and prone sleeping position.
- In police interviews, the daughter indicated that she was confused by the safe sleep training she received and had gotten mixed messages on appropriate sleep position.
- During the investigation into the death, police found marijuana in the child care center. The daughter admitted to daily use, although she said this was done when the center was closed or at her own home



## Findings

### ***Unsafe sleep conditions were present in every death reviewed.***

In 2011, the American Academy of Pediatrics updated its safe sleep recommendations to prevent SIDS and other sleep-related infant deaths. The current recommendations include:

- Placing the infant on their back to sleep;
- Using a firm sleep surface;
- Keeping soft objects and loose bedding (blankets, pillows, etc.) out of cribs and bassinets;
- Preventing bed sharing; and,
- Avoiding smoke exposure and overheating.<sup>42</sup>

The OIG reviewed autopsies and police reports to identify which risk factors were present in each SUID case. The most common unsafe sleep practices in these cases were a prone (on the stomach) or side sleeping position, or loose or soft bedding. Sleeping on the stomach or side was found in eight of 11 cases. Soft or loose bedding was found in 10 cases.

In a few of the cases, the lack of an appropriate crib or sleeping surface contributed to the unsafe sleep environment. Bed sharing was found in two of the cases and environmental tobacco smoke was noted in three of the cases.

In some cases, no information was available on whether specific risk factors were present or not. This was either due to a lack of reliable information provided by caregivers to the authorities or an investigation and autopsy that did not thoroughly follow SUID Investigation guidelines developed by the CDC.<sup>43</sup>

The OIG also tracked information, when available, on the adequacy of prenatal care, maternal age (20 and under), and whether an infant had been born prematurely or with low

birth weight. These factors have also been identified as possible risk factors for SUID.<sup>44</sup> Two cases had mothers 20 and younger, two infants were born prematurely or with low birth weight, and one case had a mother who received limited prenatal care.

The presence of unsafe sleep environments in all of these cases suggests that the deaths included in this report were at least somewhat preventable, had caregivers had access to and implemented appropriate safe sleep practices.

### ***Licensed child care center standards allow too much time to take critical safety training.***

In April 2016, there were 3,362 licensed child care facilities in Nebraska. DHHS Division of Public Health licenses five types of programs: Family Child Care Home I, Family Child Care Home II, Child Care Center, School-Age Only, and Preschools.

Regulations stipulate that the Department will conduct unannounced inspections at least once a year of child care programs. (Family Child Care Homes and Preschools) licensed for 29 or fewer children; and at least twice a year of all licensed child care programs with capacities of 30 or more.

By law, DHHS requires that licensed child care facilities have training on SIDS.<sup>45</sup> In addition, DHHS has promulgated extensive licensing requirements for child care facilities.<sup>46</sup>

Under those licensing requirements, all licensed daycare child care providers are required to complete training developed by the Early Childhood Training Center, which includes SIDS, safe sleep, shaken baby syndrome, and child abuse/neglect and reporting. In Nebraska, the

accepted training to meet this requirement is entitled “Safe With You.”

New daycare centers are issued a provisional license, which requires them to complete such training within three years of gaining licensure and every five years afterwards.

In Family Child Care Home I & II programs, it is the primary provider who must take the training. In Child Care Centers, the directors must take it. As of May 2016, at least half of the teachers in each center must take it.

All licensed programs have three years to take the training. If they were licensed on or before May 20, 2013, they must have completed the training by May 20, 2016. For center-based programs licensed on or before May 20, 2016, at least 50 percent of their staff must have taken the training. For those programs licensed after May 20, 2013, they have three years from their provisional license date to complete the training.

Two of the four child care providers who experienced a SUID case had not yet taken SIDS/Safe Sleep training when the infants died in their care.

And while DHHS licensing regulations stress that infants must be placed on their backs to sleep (unless there is a medical reason for a child to sleep in a different position) and require that there be no soft items, loose blankets or other items present, it appears there is no or little ongoing follow-up emphasis on this after initial training.

In 2015, DHHS’s 23 daycare Child Care Inspection Specialists conducted a total of 5,420 inspections and also investigated 554 licensed child care complaints and 118 unlicensed child care complaints. Given this heavy caseload, the OIG has concerns that the inspection specialists

might not have adequate time to make thorough safety checks.

***CFS and its contractors lack training, resources, and policy related to infant safe sleep***

All the cases of sudden infant death that had prior child welfare involvement had preventable risk factors. In every case, the infant was sleeping with soft bedding, in an unsafe sleep position, or both. If system-involved families had been provided safe sleep information, there is a chance that death may have been avoided.

Through its investigation, the OIG learned that there is a lack of training, resources, and policy related to infant safe sleep and SUID prevention at both CFS and Nebraska Families Collaborative (NFC), the agency responsible for case management in Douglas and Sarpy counties. Currently, unsafe sleep is only covered in CFS training as one of the physical living condition hazards listed in the Program Memo detailing factors considered as part of the Assessment of Placement Safety and Suitability.<sup>47</sup>

All CFS and NFC staff and supervisors interviewed indicated that they had had no training or extremely limited training on infant safe sleep. Some staff had knowledge of safe sleep recommendations, but this was usually from their own experience as parents or grandparents, rather than information provided to them by their employer.

Except for the Eastern Service Area Initial Assessment (IA) teams, staff and supervisors also told the OIG that they did not have informational brochures or resources about safe sleep that they could leave with families. While policy requires a walk-through of the house, including the sleeping area, during Initial Assessment, staff and supervisors indicated that it was not standard practice to ask questions or

provide information about infant safe sleep unless a concern had already been identified.

Staff at NFC and CFS responsible for ongoing cases, also indicated that it was extremely rare for them to discuss infant safe sleep with parents and caregivers. The OIG learned that thorough walkthroughs, including the infant's sleeping area, of foster homes and other

placements have not been routine. After one death, NFC changed policy to require a comprehensive walk-through including the sleeping area. Information from the walk through is captured on a form, however, there are no questions included about infant safe sleep. To the OIG's knowledge, CFS does not have a similar form.

## OIG Recommendations/Agency Responses

### 1. Adopt policy and procedure on checking infant sleep areas and asking about safe sleep in child welfare cases.

The OIG recommends that DHHS develop and NFC expand their current policies on checking infant sleep areas to capture information on infant safe sleep environment. Currently, policies do not require staff to cover safe sleep recommendations or ensure that this is occurring during home visits or walkthroughs. The Division of Public Health has a simple eight-item safe sleep checklist used by home visiting programs to capture information on how infants are sleeping and to identify any needed follow up. The OIG recommends that DHHS and NFC adopt a similar checklist to use in cases involving infants. The OIG also recommends that DHHS and NFC adopt a procedure on providing information about infant safe sleep to parents and caregivers.

#### **DHHS Response: Accept**

The Division of Children and Family Services agrees with this recommendation and is exploring how to integrate safe sleep practices into policy and procedure. CFS is interested in the results of the Safe Sleep Environment checklist being tested by the Division of Public Health (DPH) and adopting it for child welfare cases involving infants.

#### **NFC Response: Accept**

NFC agrees with this recommendation and has implemented the walkthrough guide that caseworkers use during each home visit. We will be adding infant safe sleep questions assessing environment and practices to the document and modifying the practice requiring staff to discuss this issue.

#### **Status Update: *Progress***

The Division of Public Health finalized a Safe Sleep Environment Checklist, which CFS is integrating into policy. In July, NFC implemented a new portion to its walkthrough process where there are children age two and under in the home. A checkbox was added to the walkthrough checklist form that requires the Family Permanency Specialist to indicate (when applicable) that he or she spoke with the placement

about safe sleeping guidelines and viewed the area where the child sleeps. Additionally, it prompts the FPS to discuss co-sleeping as part of the safe sleep discussion. NFC also added a handout developed by DHHS called “*Safe Sleep for Your Baby*” that is attached to the checklist and the FPS gives to the caregiver each time they do the walkthrough. The walkthroughs are done monthly for all non-licensed homes. For homes that are licensed, the Child Placing Agency handles education about safe sleep.

## **2. Enhance training, resources, and education available to staff, parents, and caregivers in child welfare cases.**

Training or educational resources on infant safe sleep are not readily available to CFS and NFC employees in the field. Subsequently, parents and caregivers involved in the child welfare system receive limited information. The OIG recommends that CFS work with the Division of Public Health and others engaged in SUID prevention to develop training as well as resource materials that staff can use anytime they have a case that involves an infant. Given the large number of resources and training curricula that are widely available, the OIG believes that it will be relatively simple to incorporate information on safe sleep into ongoing training for staff and make brochures and other educational resources available to staff and families.

### **DHHS Response: Accept**

CFS agrees that more training, resources, and education regarding safe sleep should be available to staff, parents and caregivers in child welfare cases. CFS will continue to work with DPH to improve knowledge of and utilization of safe sleep practices. By July 2016, CFS will significantly enhance the information about infant safe sleep practices in new worker training. The DHHS Training System Team will work with DPH to develop the specific learning objectives for CFS Specialists. In addition, CFS will distribute information about safe sleep in an upcoming “Message from Training” email to all CFS staff.

CFS will provide safe sleep resources (in both English and Spanish) to CFS Specialists to distribute to parents and caregivers of infants. Currently, the Initial Assessment staff in the Eastern Service Area distribute an “Under Two Packet” to families with children under the age of two. The “Under Two Packet” contains information on safe sleep—including safe sleep tips for your baby and resources. In partnership with DPH, CFS has reviewed the materials and is creating a statewide packet for staff to distribute when they assess or work with a family with an infant. In addition to the packet, CFS is working on alone page, laminated visual for families with pictures and simple tips for parents.

### **NFC Response: Accept**

NFC agrees with this recommendation. Infant safe sleep has been added to the required training curriculum at NFC. A plan is being developed that will include training for all new hires and annual refresher training for all existing FPSs.

NFC modified practices regarding missed medical appointments for infants and children ages 5 and under. This practice will support staff knowing when appointments are missed therefore being able to follow up with the care provider.

Information on infant safe sleep will be added to packets provided to parents when they are referred to NFC. Staff will also be asked to review this information with parents/care takers of children referred to NFC that are under the age of 2 years old.

**Status Update: Complete**

DHHS: Beginning with the July 2016 New Worker Training group, information related to safe sleeping was included in the Development, Behavior, and Mental Health Issues and Resources unit. The job aide that accompanies that unit will be updated to include safe sleep information. Safe sleep is also discussed during Maltreatment and APSS and Out-of-Home Assessments units. An “under 2 packet” with information about safe sleep was created with assistance from the Division of Public Health and distributed at the April 2016 Operations Meeting. The packet is available in English and Spanish and is available on SharePoint. Trainees are directed to utilize the under 2 packets. In addition, the information was sent to existing staff through a Message from Training on June 28, 2016.

NFC created an online training platform that has been added into its Initial Training (mandatory for all new hires in the Family Permanency Specialist role). This is also available to all FPS staff, who must complete it by the end of 2016. To date, approximately half have completed the training.

### 3. Revise regulations to require childcare center training before granting a license.

DHHS should require all licensed child care providers to complete the existing training developed by the Early Childhood Training Center, which includes Sudden Infant Death Syndrome (SIDS), safe sleep, shaken baby syndrome, and child abuse/neglect and reporting *before* being granted a provisional license. Minnesota, for example requires Family Child Care professionals to take training for SIDS/Shaken Baby prevention, CPR and First Aid before they can begin caring for children. The training must be renewed annually. As part of the 2014 reauthorization of the federal Child Care and Development Block Grant Act, all states are required to implement safe sleep training for child care providers by September 2016. In anticipation of this, Colorado promulgated new rules for Family Child Care Homes and Child Care Centers in the spring of 2015 specifically addressing safe sleep environments and includes the requirement that any staff working with infants or toddlers complete a department approved safe sleep course before working with children and must be completed on an annual basis.

**Agency Response: Accept**

It is the plan to move forward with a revision of the regulations for all licensed child care programs in the next 18 months. It will be a program recommendation to require the training regarding safe sleep practices, shaken baby prevention, and child abuse/neglect reporting before the issuance of a license. That recommendation will need to be approved through the regulation promulgation process.

Currently, regulations specific to safe sleep practices are reviewed with applicants before a license is issued. Family child care programs are required to attend a two-hour orientation training before they

receive their license. The regulations specific to safe sleep environments and placing infants on their backs to sleep is highlighted during this training. In addition, all licensed have a pre-license inspection. Again, the regulations are reviewed with all applicants as well as at subsequent annual/semi-annual inspections.

Given the number of deaths in licensed child care programs since 2013, the Licensure Unit has begun to develop strategies to address the problem. Those strategies include significantly highlighting the safe sleep regulations during orientation training, making it a point of emphasis during pre-license inspections and encouraging all licensees and their staff to attend the '*Safe with You*' training as quickly as possible.

Children's Services licensing will continue to collaborate with interested entities in order to develop targeted educational efforts, including the distribution of safe sleep materials that will be shared with licensed programs as well as the parents they serve.

**Status Update: *Incomplete***

Public Health reports that it is moving forward with a revision of the regulations for all licensed child care programs in the next 18 months. Public Health will recommend that the training regarding safe sleep practices, shaken baby prevention, and child abuse/neglect reporting training be required before the issuance of a license.

OIG Comment: If DHHS is not able to expedite the change, swift Legislative action should be considered.

## Investigation Summary:

### Suicides of State Wards

#### Suicide of a State Ward at Home

A 16-year-old state ward committed suicide by hanging herself in her bedroom in her family home after an argument with her mother. The autopsy found amphetamines in her system and a blood-alcohol level of 0.158.

The youth was placed in the custody of the state Department of Health and Human Services (DHHS) as an Office of Juvenile Services ward for approximately 18 months before her death due to truancy and aggressive outbursts at school. During her time in DHHS care she was diagnosed with both depression (ADHD), for which she was taking medication. An assessment completed while she was in DHHS custody, also indicated that the youth likely had a history of significant trauma.

#### Investigative Findings:

*Though the youth was ordered to attend therapy sessions, little was done to ensure that she was attending.*

The OIG investigation found that the youth's case managers were unaware that she had stopped going to therapy until her therapist sent a letter less than a month before her death saying she had not seen her in five months. Even after the letter was received, the youth shared with Children and Family Services (CFS) staff that her boyfriend had been murdered, and other professionals told CFS that the youth seemed depressed, the case manager at the time did not contact the therapist or arrange for an appointment.

The youth's mother, a Sudanese immigrant with limited English skills, and the youth reported that it was difficult to find the "right words" to communicate with her. One of the youth's DHHS caseworkers said the mother's cultural background limited her view on the importance that her daughter attend therapy.

*There were failings in making sure the youth was properly taking her medications; DHHS lacked protocols for health care management, especially concerning psychotropic medications.*

The OIG investigation found that the youth had not filled her prescriptions for psychotropic medications and appeared to not be taking them for at least a month in the lead up to her death. At the time the youth was in care, DHHS did not have any policy on how case workers were supposed to give consent for youth to start medication, how medication use was to be monitored for compliance, or how staff was supposed to coordinate with medical professionals.

The caseworker told the OIG that even though the youth's mother worked nights, she was responsible for making sure her daughter took her medications and attended therapy. DHHS staff shared that the language barrier and cultural beliefs of the mother made this more difficult.

*There was sporadic coordination and communication between key professionals involved in the case.*

In the last two months of the youth's life, her case transferred to a different case manager two different times. As the case was transferring for the last time, the prior case manager was supposed to set up a therapy appointment, but had failed to do so. He did not tell the new case manager that he had not done so until three days before the youth's death.

The OIG also found that case managers did not keep in regular contact with other professionals serving the youth. In addition to the lack of contact with the therapist, the tracking program monitoring the youth sent a note to DHHS some six weeks before her death that the youth had tested positive for amphetamines and marijuana. There was no notation by DHHS in the youth's records that this was addressed with her or her mother.

*The investigation raised concerns about whether the needs and stressors of the youth and her family were adequately addressed.*

While in DHHS custody, the youth had a comprehensive child and adolescent assessment completed by mental health professionals. The report raised concerns about the mother's ability to effectively supervise the youth, given her work schedule and cultural and language barriers that the family faced. The assessment also highlighted concerns that the youth, "may have been through some form of significant trauma, possibly a sexual assault in the past year." Records reviewed suggest there also were concerns about relationships between the youth and her siblings, in particular how her older brothers treated her, including some physical violence in the home.

The OIG did not find any documentation or information in interviews to suggest that the family needs or stressors were addressed.

## OIG Recommendations and Agency Responses:

### 1. Adopt federally mandated policies and procedures on mental and behavioral health care as soon as possible

Federal law requires DHHS to have clear policies and procedures in place for overall health care coordination (including mental health) and oversight of psychotropic medications for children in foster care. Despite federal guidance and state level interest, DHHS has not yet adopted clear policies. In this case, the lack of clear policy contributed to a lack of coordination—failings in making sure the youth was taking her medications and refilling prescriptions as well as making sure she was attending therapy sessions—which resulted in the delivery of insufficient, ineffective care, and likely played a role in her eventual suicide. The OIG recommends that DHHS adopt policies and procedures in federally required areas (use and oversight of psychotropic medications; mental health and trauma screening and treatment; and sharing and updating of medical information) as soon as possible.

#### **Agency Response: Accept**

DHHS accepts this recommendation and has continued to work with other system partners on the development of protocol for psychotropic medication monitoring and the coordination of medical and behavioral healthcare for children involved in the child welfare system. In 2012, CFS convened a Healthcare Oversight Committee. This federally required, multidisciplinary team meets every other



month and consists of representatives from Medicaid, Magellan, the Division of Behavioral Health (DBH), psychiatrists, therapists, foster parents, pediatricians and CFS. The purpose of this committee is to provide consultation in the development of a 5 year Health Care Oversight and Coordination Plan in accordance with Section 422(b) (15) (A) of the Social Security Act, which identifies the coordinated strategies to identify and respond to the health care needs of children in foster care placements, including mental health and dental health needs. Monitoring psychotropic medications for children in foster care is one component of the Health Care Oversight and Coordination Plan.

The Healthcare Oversight Committee was instrumental with developing the, “Psychotropic Medication Guidelines for Children in the Child Welfare System.” CFS utilized these Guidelines for the development of the Program Guidance Memo entitled “Monitoring Psychotropic Medications and Coordinating Healthcare.” This recently drafted Program Guidance Memo identifies the specific procedures to be used for monitoring psychotropic medications, informed consent and coordinating the medical and behavioral healthcare needs of children served by CFS. CFS has asked for representatives from the 5 CFS Service Areas to review and provide feedback of the draft memo which is scheduled to be finalized and released no later than March 30, 2016. In addition to developing the Program Guidance Memo, in April 2015, CFS released major N-Focus enhancements to the SACWIS system. These enhancements enabled our staff to collect, store and report on numerous person conditions. These person conditions include diagnosis, behavioral conditions, professional relationships, allergies, medical appointments and medications, including drug name, dosage, and an indicator if the medication prescribed is a psychotropic medication.

Psychotropic medication monitoring will continue to require cross-system collaboration. Medicaid adopted the following psychotropic medication criteria. These criteria were based on recommendations made by the Drug Utilization Review (DUR) Board which was adapted from the *Psychotropic Medication Utilization Parameters for Children and Youth in Foster Care, September 2013*, developed by the Texas Department of Family and Protective Services and The University of Texas at Austin College of Pharmacy.

For children who receive Medicaid, claims processed by Medicaid have to meet the requirements set in place by the guidelines. A prescription claim will be denied by Medicaid when a prescription falls outside of the guidelines requiring the Medicaid Long Term Care (MLTC) Point-of-Sale (POS) contractor and MCO Pharmacy Benefit Managers (PBMs) review for approval (Refer to Appendix document, Nebraska Medicaid Prior Authorization Process) before approving the prescription. When prescription claims are denied, the prescribing practitioner will follow the process outlined in the ‘Nebraska Medicaid Prior Authorization Process.’

#### **Status Update: *Progress***

Psychotropic Medication Program Guidance (Division of Children and Family Services Protection and Safety Procedure # 11-2016) that outlines a process for informed consent, coordinating and sharing information, and supervisory monitoring, completed in April 2016. Modification to N-FOCUS to capture “conditions” completed in April 2015. DHHS expects to adopt policy on mental health and trauma screening later in the fall of 2016.

## 2. Enhance efforts to reduce caseworker turnover.

A 2009 study of Texas CPS caseworkers by the Center for Public Policy Priorities said that “the child or family does not care why the worker changed, only that they now must establish a relationship with someone new, which often delays or disrupts services and the case plan. “Turnover also affects families with workers who have not left. While recruiting, hiring and training new workers for the vacant positions, remaining workers must manage the cases of departing workers. This increases caseloads and reduces the time and energy spent on any individual child or family.”<sup>48</sup>

In addition, a 2014 white paper by Judge James Payne of Public Consulting Group Inc. concluded that that continuity of case management care has been shown to be an important factor for positive child and family outcomes within the child protection system.<sup>49</sup>

Payne noted that when a case must be transferred due to turnover or other organizational factors, a new caseworker is required to review all of the work that has been done by the prior caseworker(s) across all of the different systems that may have been involved in the case.

The OIG believes DHHS should consider a number of steps recommended by Payne to reduce case transfers and improve outcomes for children:

1. Calculate reasonable caseloads that fully consider workload and allow workers to take on additional cases from time to time;
2. Overfill positions so that when one caseworker leaves another can step in immediately to permanently carry the case;
3. Implement teaming or dual caseload assignments;
4. Consider the need for and number of functional specializations; and
5. Use data to effectively monitor and manage the items above.

### **Agency Response: Accept**

DHHS accepts this recommendation and will continue to implement and monitor strategies designed to reduce case manager turnover, examples include:

1. Retaining Employees-Statewide Focus Group: In December 2014, a team of case managers from each of the five Service Areas was convened by the Field Operations Administrator and the Deputy Director of Protection and Safety in order to learn more about why case managers leave CFS. In partnership with Human Resources, CFS identified the primary reasons for turnover/vacancies and have implemented strategies based on the Focus Group’s recommendations. Examples of strategies include:
  - Customize Training for Protection and Safety Supervisors: CFS leadership is working with DHHS Professional Development (Training) staff to create a training that specifically addresses the challenges of supervising protection and safety supervisors and includes

techniques on how to identify and effectively manage vicarious trauma and methods to create and sustain a culture of resiliency.

- **Hiring the Right People:** CFS has recently changed how applicants are selected for an interview. Applicants are now screened via an initial phone interview before formal interviews. CFS has also updated and revised case manager interview questions to be more in line with the attributes of strong case managers.
2. **Using Data to Monitor Vacancies:** In partnership with Human Resources, a monthly “Turnover/Vacancy Report” was automated in January 2016. This report utilizes a common definition for identifying and reporting aggregate and service area specific turnover data and is a tool to identify potential trends as well as assist with managing FTE’s.

### **Status Update: *Progress***

The agency developed and completed a “Realistic Job Preview” for prospective employees in April 2016 and began using supervisory training in May 2016.

## Suicide of a State Ward at Treatment Facility

A 17-year-old state ward committed suicide by hanging himself with a belt on playground equipment outside of the a psychiatric residential treatment facility (PRTF), where he lived at the time. The OIG investigation focused on policies and procedures regarding self-harming and suicidal youth that were placed in a PRTF facility and whether they were followed. Since three other investigations were done after the suicide by DHHS and Magellan, and the facility eventually surrendered its license, the OIG made no recommendations in this case.

### Investigative Findings:

The DHHS Division of Child and Family Services, the Division of Public Health, and Magellan Behavioral Health – under contract with the Division of Medicaid and Long-term Care – each conducted investigations after the youth’s suicide.

Those investigations revealed inadequate training of some staff and supervisors and failure to implement or follow emergency response policies and procedures, which helped lead to the youth’s death. The OIG concurred with these findings, which concluded that the PRTF failed to follow its own policies. Because the facility surrendered its certification to operate the PRTF after the suicide rather than be subject to the

Corrective Action Plan set forth by the DHHS Division of Public Health, the OIG made no recommendation in this case.

The collective record shows abundant evidence of a lack of training of staff and supervisors and failure to implement or follow emergency response policies and procedures, even though another youth had committed suicide at another mental health facility of the same provider some 13 months before the youth’s death.

According to records, the youth had a mental health assessment and a current Master Treatment Plan – developed and signed by the PRTF staff – that listed self-harming and suicidal ideation behaviors as concerns for the youth.

According to the Out-of-Home Assessment completed by CFS after the death, the PRTF staff members that provided direct care for the youth were unaware of his suicidal ideations -- and some were even unaware that he was ever on self-harming/suicidal warnings despite having a current diagnosis, a current Master Treatment Plan and the fact that he wrote in his journals at least 10 times about his thoughts of suicide and possible ways to kill himself.

The PRTF's policy said only a therapist could read a journal marked "Therapeutic." Although the PRTF's residential manager and other staff were aware that therapeutic journals were to be used not only for therapy but also for safety plans, there was no policy or procedure in place to have anyone monitoring these journals.

The youth had three journals, and only one was labeled "Therapeutic." Yet none of his journals were monitored. Had the journals been reviewed by the PRTF staff, they would have been aware that the youth was not only having suicidal thoughts, but was making a plan, according to an assessment of the facility after the youth's suicide.

Records show there was no direct policy or procedure provided to investigators regarding the 15 minutes of "free time," including the amount of supervision, where youth were allowed to go or what they are allowed to do. There was no direct policy or procedure provided to DHHS about who was responsible for monitoring a youth's 15 minutes of free time, during which they had access to the entire campus -- which made it nearly impossible to monitor them adequately.

Magellan Health Services reported after the suicide that she was concerned about the specific PRTF having *"a systemic problem that has weakened their compliance with their own risk-management policies."*

The facility was certified as a PRTF through the Centers for Medicare and Medicaid Services from Aug. 2004 until Jan. 2013, when it surrendered its certification.

Records provided by DHHS show the PRTF facility was cited in September 2009 for failure to have policies and protocols in place to investigate "unknown injuries" and/or "suspicious occurrences during behavioral interventions to ensure the protection of clients."

In April 2011, DHHS issued corrective actions to the PRTF for not meeting standards for restraint and seclusion policies and not keeping up-to-date contact information for residents' appropriate service providers.

As noted earlier, DHHS had cited another facility under the same management in relation to the death of a client who hung himself in a shower 13 months before this suicide. DHHS's Public Health Licensure Unit investigated the previous suicide, and the facility was given a Notice of Disciplinary Action that imposed a \$10,000 fine and a term of one year probation. That action prohibited the facility from maintaining or admitting children with history of suicidal attempts. The following year, the facility voluntarily terminated its Mental Health Center license.

The OIG made no further recommendations.

## Investigation Summary:

### Death of Youth Served by Probation & DHHS

A 16-year-old supervised by the Administrative Office of Probation (Probation), receiving voluntary services from the Department of Health and Human Services' (DHHS) Division of Developmental Disabilities (DD), and placed in out-of-home care died due to hypothermia while on a weekend visit with family. The autopsy found acute ethanol intoxication (an ethanol level of .186) as a contributing factor in the death as well as the presence of cannabinoids (compounds present in marijuana). Up until two days before his death, the youth had been a state ward in the care of the DHHS Division of Children and Family Services (CFS).

The youth had a long history with both the child welfare and juvenile justice system, due to behavioral issues stemming from his developmental disabilities, which included an Autism diagnosis. The youth was first made a state ward for uncontrollable behavior (a status offense) between the ages of 7 and 8 to access DD services. The youth was again made a state ward for uncontrollable behavior at the age of 14, but was transitioned to Probation supervision as part of juvenile justice system reform efforts six months before his death. After Probation had difficulty with the youth's mother, a child neglect petition was filed and the youth returned to CFS custody as part of a child welfare case, in addition to continuing under Probation supervision. DD services continued throughout this period of time. Two days before the youth's death, the child welfare petition against the mother was dismissed, and the CFS case was closed.

The OIG prepared two separate death reports for DHHS and Probation related to this case. Summaries of both reports, recommendations, and agency responses follow. Probation's report was issued during the 2015-16 fiscal year, and the report to DHHS was issued early in the 16-17 fiscal year. Both summaries were included in this year's report to ensure that the case was accurately and completely represented.

## Probation Report

### Investigative Findings:

#### *Lack of policy and training on key issues lessened Probation's effectiveness in providing supervision.*

The OIG investigation found that Probation lacked policy and training on key issues that impacted the youth and family in this case. These issues include:

- *How to effectively work with youth who have intellectual and/or developmental disabilities (I/DD).*

The youth in this case was diagnosed at an early age with Autism spectrum disorder, a type of developmental disability characterized by social

impairment, communication difficulties, and repetitive and characteristic behaviors.<sup>50</sup> While supervised by Probation, the youth refused to comply with many of the conditions of Probation, including submitting to drug tests, which meant his substance abuse went undetected. It was unclear to Probation staff whether this was part of the disability or just defiant behavior. Without resources and key tools available to them, staff did not know how to manage the youth's case.

There was and is no Probation policy, procedure, or training available on identifying, screening,

effectively engaging with youth with I/DD (beyond motivational interviewing), or providing them specialized supervision and services. Interviews with Probation staff indicated that knowledge of the programs available to children through the Division of DD is also limited.

- *How to identify cases that may be appropriate for child welfare involvement and how to refer these cases;*

At the time the youth was involved with Probation, there was no training or guidance available about when cases should be referred to the child welfare system and how that should occur. When the youth's mother made parenting decisions that were questionable or concerning, Probation requested that the county attorney file a petition alleging the mother was neglectful and to return the youth to CFS custody. Nebraska law outlines the process of reporting suspected child abuse and neglect – either to law enforcement or the CFS hotline.<sup>51</sup> This process was not followed.

The decision to go to the county attorney led to mistrust between Probation and CFS, and between Probation and the youth's mother. CFS and Probation did not communicate or cooperate on how best to serve the youth as they were focused on which system would be responsible for the youth's care. The poor relationship with the mother encouraged her to support the youth's desire not to follow the Probation order.

- *Coordination and joint case management standards when a youth is involved with both CFS and Probation.*

For the majority of the six months before the youth's death, both DHHS and Probation were involved with the youth and the family. However, communication and coordination between the two entities was minimal.

Interviews with staff at both agencies revealed that they had little knowledge of what the other was doing. There was a failure to coordinate on addressing the youth's use of substances or ensuring appropriate supervision was occurring.

Probation has no policy or training available to staff on how to coordinate when a CFS case is open while a youth is also under probation supervision. And while there are general expectations on collateral contacts contained in Probation's Responsive Case Management Standards, they are focused on providers and do not address joint case management or planning, including identifying needs, ensuring appropriate services are offered, and communicating effectively between Probation and CFS.<sup>52</sup>

***Confusion about roles and responsibilities prevented and delayed the youth's needs from being met.***

Disagreements between agencies serving the youth occupied much of the time of direct care staff and administrators alike in the months leading up to the youth's death. For Probation, most of the confusion about roles and responsibilities was focused on whether the youth should be supervised by Probation at all. Although the youth was a status offender and had recent law violations for minor in possession, local Probation staff's opinion was that a youth with I/DD and family concerns, should never be placed on probation.

Initially, staff time was spent on attempting to get the case back to CFS. Once the youth was dually-adjudicated, Probation played a smaller role in the case, expecting CFS to take the lead. However, CFS, which handles exclusively abuse and neglect cases after juvenile justice reform<sup>53</sup> in cases such as these, focused their attention on providing services to the youth's mother, since their case was related to her alleged

neglect. The two areas where Probation has specific expertise – addressing substance abuse and providing supervision and monitoring – were lacking in the youth’s case as a whole. With agencies at odds about who needed to provide services, the youth’s needs were not being met.

***Probation policy, processes, or protocol were not seemingly followed in a number of areas.***

The OIG did not find a case plan (also called a Team Plan) in either paper or electronic case files provided by the Administrative Office of Probation. The Juvenile Responsive Case Management Standards Protocol (RCMS) requires juvenile probation officers to create individualized case plans. Protocol advises that the plan should focus on the highest domains of risk and have clear goal outcomes and that the details of this plan be entered into Probation Information Management System.<sup>54</sup> No information in Probation records indicated that services were provided by Probation to address the areas of highest risk – family circumstances/parenting; leisure/recreation; and personality/behavior.

When the youth was assigned to Probation, the Youth Level of Service Case Management Inventory tool scored him as high risk. This meant the youth was placed under the supervision of a Juvenile Community-Based Intervention officer. RCMS indicates that such juveniles need a high level of supervision, will be the priority of supervision resources, and, “will be intensively supervised.”

Probation supervision of the youth was limited. The RCMS protocol requires that qualitative and quantitative home visits occur once every 60 days for higher risk juveniles.<sup>55</sup> However, there was no record of home visits with the youth either at their family home or at the developmental disabilities host home for the six months the youth was supervised by Probation.

There were also indications from other documents reviewed by the OIG that there were signs of the youth’s troubling behavior, especially related to substances, that went undetected. The out-of-home provider for the youth indicated that there were issues with the youth using substances. Probation was unaware of these concerns until after the youth died.

The OIG also found that Probation did not follow its Enhanced Family Engagement Principles, which include respecting the family, encouraging the family’s participatory role, and empowering families to change.<sup>56</sup> The youth’s mother had a history of being difficult or contrary with agencies involved in her son’s life. Probation dismissed family concerns about how the youth’s out-of-home placement was caring for him (despite evidence there were concerns), and also did not alter the form of drug test from urinalysis, despite family reports that the youth’s disability made it impossible for him to drug test using that method.

***Lack of documentation limited the OIG’s ability to fully determine how Probation acted and whether policies and procedures were followed.***

Probation, at both the statewide and local level, does not have many specific requirements for documentation of case management and supervision of youth placed on Probation. There does not seem to be a standard procedure for what should be recorded. This is problematic not only for any internal quality assurance efforts that Probation is conducting, but also for those providing outside government accountability. The lack of documentation hampered the OIG’s ability to determine whether all Probation policies were followed, and the extent of interventions that Probation attempted with the youth in this case.

## OIG Recommendations and Agency Responses:

### 1. Adopt training and policy on supervising youth with intellectual and developmental disabilities (I/DD)

While limited, the available research suggests that youth with I/DD are overrepresented in the justice system, which is often ill-equipped to recognize and effectively work with these youth. One study estimated that 65 to 70 percent of justice-involved youth can be classified as having a disability. This number is based on a broad definition of disability, including not just youth with I/DD, but all those who are provided protections under the Individuals with Disabilities Education Act and Americans with Disabilities Act.<sup>lvii</sup>

Currently, Probation has no training or policy on identifying or effectively supervising youth with I/DD. While no data is currently available on the number of Nebraska youth with I/DD on Probation, interviews with Probation staff at all different levels indicate that they come across youth with disabilities on a regular basis and struggle to know how best to handle these cases. It is also likely that there are a significant number of youth currently on Probation who have an undiagnosed disability that impacts the effectiveness of Probation's services and the youth's success.

The OIG recommends that the Administrative Office of Probation develop training for juvenile officers on identifying and working with youth with I/DD. The OIG also recommends that a formal policy be put in place to ensure that youth are screened for possible I/DD, as well as one for handling ongoing case management and supervision for youth with I/DD.

### 2. Adopt policy on child welfare referrals and joint case management

DHHS and Probation recently began tracking the number of dually-adjudicated youth on a monthly basis. Probation administrators estimate that as of May 2016, about 5 percent of all probationers are dually-adjudicated. The larger number of youth supervised by Probation, who are also dealing with child maltreatment issues or whose families are receiving voluntary services, is not yet able to be captured.

Based on research indicating the dually-involved youth often experience poor outcomes, a reform effort to better serve youth served by the child welfare and juvenile justice systems has begun nationally.<sup>lviii</sup> Nebraska has participated in one such reform effort, the Crossover Youth Practice Model, since 2012 in Douglas County. Currently, five Nebraska counties have local teams.<sup>lix</sup> The goal of this reform is both to better-serve youth and cut down on systemic inefficiencies. However, neither Probation nor the Division of Children and Family Services (CFS) have adopted policy on a statewide level that sets clear requirements on how staff refer youth to the other system or how cases that are dually-adjudicated should be managed.

This child's death illustrates the need not only for CFS and Probation to work together more effectively, but for each agency to adopt clear policy for their staff in the field on how to handle these complicated



cases, regardless of the action the other agency takes. To that end, the OIG recommends that Probation adopt policy in two key areas that created issues in this case.

1. Probation should provide staff with a uniform process for making referrals to the child welfare system in compliance with the state's mandatory child abuse and neglect reporting laws. This policy should also clearly spell out what the expectations are for Probation to address family issues or parenting concerns, when there is no child welfare involvement because a case did not meet criteria for CFS involvement.
2. Probation should adopt policy on joint case management, including how Probation will share and gather information from CFS and how case plans will be coordinated (or jointly planned when appropriate).

### 3. Adopt policy on documentation and record keeping

A lack of documentation made it difficult to determine whether Probation's policies and expectations for its employees were completely followed. Currently, Probation does not have statewide policy or protocols on what should be documented, where (electronically or paper file), and when it should be entered. The OIG recommends that Probation develop statewide standards on documentation and record keeping. This will greatly enhance both internal and external ability to monitor quality and compliance.

### 4. Increase internal quality assurance efforts at the state level

In this case, key requirements of Probation policies were not followed, including case planning, home visits, and family engagement. Interviews with administrators indicate that problems with missing Team Plans are known to be fairly widespread. Given these issues, the OIG recommends that the Administrative Office of Probation take steps to enhance its statewide quality assurance work for juvenile cases.

Through interviews with administrators, the OIG learned that the Administrative Office of Probation has a limited capacity for quality assurance at the statewide level. In fact, statewide quality assurance efforts have only been in effect since 2010 and are primarily focused on district evaluations, which occur once every two years or so, and only encompass a certain number of topics. According to interviews with administration, quality assurance is primarily delegated to the chief deputies in each District.

The OIG recommends that Probation specifically enhance its ability to generate data reports on a frequent, ongoing, and consistent basis to determine compliance with essential policy requirements. The percentage of Team Plans that have been completed and the percentage of home visits that are occurring in a timely fashion, are two areas that may be helpful starting points. Compliance with statewide policy is likely to improve if staff and Districts are measured on key processes on a frequent (at least monthly), ongoing, and consistent basis by state administrators.

#### **Agency Response: Probation rejected the report.**

The agency indicated that the OIG's recommendations will be considered in the continual process of evaluating their practices and policies as the Probation Administrator deems appropriate.

## DHHS Report

### Investigative Findings:

#### ***Disagreement and confusion between divisions and agencies prevented the youth's needs from being met in a timely manner***

The OIG received and reviewed more than 1,000 pages of email correspondence to and from CFS employees related to this case in the months leading up to the youth's death. The emails primarily focused on disagreements with or confusion about how to approach the other two entities serving the youth – the Division of Developmental Disabilities and Probation. Emails and interviews with staff revealed that confusion, lack of coordination and knowledge, and ongoing differences of opinion between agencies about who should serve the youth detracted from the case.

- *Disagreement with the Division of Developmental Disabilities*

Interviews with CFS Administrators revealed that during the time leading up to the youth's death, the relationship between CFS and DD was strained. CFS felt that the former Director of DD was making strange and arbitrary decisions that made it more difficult for youth to qualify for DD services. There was also a perceived pattern of youth in CFS care who had been eligible for services from DD for years, being suddenly found ineligible for services. The burden of paying for services would then fall to CFS, which had to keep cases open that perhaps could have otherwise closed.

The widespread mistrust between the two divisions took up great amounts of time in this

case. DD was providing the youth with a service coordinator and paying for his out-of-home placement at an extended family home, a home providing DD services, for at least a year before his death. DD was concerned about the youth returning to his mother's custody when the case transferred to Probation. In addition to arguments about continuing DD funding, CFS was concerned that DD was working with Probation to discharge the youth from Probation supervision, while ensuring a child welfare case would remain open. An evaluation of the youth that DD paid for was delayed for a number of months due to arguments over which division would provide documents to the evaluator.

- *Disagreement with Probation*

In this case, CFS and Probation disagreed on which entity should be responsible for serving the youth. Two weeks after the youth was discharged from CFS custody (as a part of juvenile justice reform), Probation worked with the county attorney to make him a state ward again. According to interviews with CFS staff, this was not an isolated incident. During the reform transition, CFS reported that other delinquent and status-offending youth with high needs or specialized care were delayed or prevented from transferring by working to make those youth state wards.

The disagreement over this case and others, led to a lack of coordination and communication in this case. There was no common case planning or regular information sharing. Once the youth

was a state ward, Probation played a smaller role in supervision and case management, leaving much of the responsibility for case planning, supervision, and decision making to CFS. However, since CFS' responsibility in the case was to address the neglect allegations against the mother, their case plan was not focused on monitoring the youth's behavior. Thus key concerns, like the youth's substance abuse, went unaddressed.

***CFS lacked policy and training on key issues***

CFS did not have policy on communication, case coordination, and joint case planning when it shared cases with Probation. In this case, the lack of policy left staff unsure of what they could expect from Probation or uncertain of how to effectively share information with Probation. The failure to coordinate meant that CFS was largely unaware of concerns with the youth's use of substances.

CFS staff also cited limited training on how to work with youth diagnosed with Autism and other developmental disabilities. CFS staff also lacked training on how the DD system worked and the different levels of care available to DD clients. The youth struggled in many of his DD homes. It was only when he moved to his last provider that he began to improve slightly, since it was a higher level home. Had CFS known about the differences in homes, CFS staff told the OIG that they would have requested a change much sooner.

***CFS did not comply with required timelines on assessments and case planning.***

CFS did provide services to the youth and family, including family support work, and made its required visits with the family. However, the OIG also found a number of instances where CFS did not follow its own policy on when assessments and case plans must be completed.

DHHS policy states that a case plan and Family Strengths and Needs Assessment (FSNA) must be completed within 60 days of a case opening.<sup>60</sup> The FSNA was completed nine days late. The case plan was not developed until over four months into the case, and just a few days before the CFS case was closed after neglect charges against the mother were dropped. The OIG also found a delay in completing a Safety Assessment. No Risk Assessments or Risk Reassessments were ever completed in the case.

It is not entirely clear why key timelines were not adhered to or assessments were not completed. Interviews with CFS staff indicate that there was a great deal of confusion about how to handle this case, given the unusual way that it came to CFS's attention (through court action rather than a child abuse or neglect investigation).

The focus for CFS field staff in this case was meeting court ordered requirements, resolving confusion over placement with DD, and attempting to have the court close the CFS involvement as they felt the allegations against the mother were baseless. In focusing on all of the other entities involved in the case, CFS did not use its own tools in a timely manner.

## OIG Recommendations and Agency Responses

### 1. Adopt policy on joint case management and case planning when a youth is involved with both the child welfare and juvenile justice system.

This death illustrates the need for CFS and Probation to work together more effectively when they are both involved in a case. DHHS and Probation recently began tracking the number of dually-adjudicated youth on a monthly basis. According to data provided by the Administrative Office of Probation, on a single date in May 2016, 177 youth were both state wards and placed on Probation. The larger number of youth who may be served through non-court services, or are experiencing child maltreatment and placed on Probation is not available.

National research indicates that dually-involved youth often experience poor outcomes.<sup>61</sup> Nebraska has participated in a national reform effort, the Crossover Youth Practice Model, since 2012 in Douglas County. Currently, five Nebraska counties have local teams.<sup>62</sup> The goal of this reform is both to better serve youth and cut down on systemic inefficiencies. However, the focus and success of local efforts has been mixed. For example, DHHS staff reported that they are often not welcome at certain Crossover Youth meetings. No coordinated, statewide effort has yet taken shape.

Neither Probation nor CFS have adopted policy on a statewide level that sets clear requirements on how cases that are dually-adjudicated should be managed by each agency. The OIG recommends that DHHS adopt policy on requirements for case management when a case is dually-involved, including how information will be gathered and shared with Probation, and how case plans will be coordinated or jointly planned when appropriate.

#### **Agency Response: Accept**

DHHS accepts this recommendation and has been collaborating with the Administrative Office of Probation (AOP) to develop a Crossover Youth Collaborative Guide to give direction to staff how to work together when youth are crossing over the child welfare and juvenile justice system. The Crossover Youth Collaborative Guide is based upon the principles of the Crossover Youth Practice Model (CYPM) developed by the Center for Juvenile Justice Reform. The draft model consists of three phases:

- **Phase I - Identification**  
The early identification of youth who cross between child welfare and juvenile justice allows both systems to collectively assess needs, expedite coordinated case planning and implement least restrictive/least intrusive interventions.
- **Phase II - Joint Assessment and Planning**  
As soon as a crossover youth has been identified, DHHS and AOP staff should begin the process of sharing information, assessment, collaborative planning with the family, and coordinating

recommendations to the court. DHHS and AOP staff shall make every effort to include education and behavioral health staff in Phase II practices.

- **Phase III - Coordinated Case Management and Ongoing Assessment of Progress**  
During this phase, both DHHS and AOP have ongoing supervisory responsibility within the youth/family's case. CFSS and probation officers work together to implement the coordinated family plan through cooperative case management, ongoing assessment of the youth's and family's progress and making adjustments to the plan as necessary.

Upon reaching consensus on the Crossover Youth Collaborative Guide, a plan will be put into place to train all child welfare and juvenile justice staff on the model and fully implemented in the spring of 2017.

## 2. Increase training and coordination between the Division of Children and Family Services and the Division of Developmental Disabilities.

The poor relationship and lack of coordination between CFS and DD detracted from this case. With the change in administration in 2015, the relationship between the divisions seems to have improved. However, a need for greater training and coordination between divisions remain.

CFS administrators shared that their understanding of how DD operates is still limited. The knowledge of field staff is even more basic as it relates to DD. The OIG recommends that training and coordination across divisions be developed, especially for staff in the field. The OIG also recommends that DHHS begin collecting and analyzing data on youth involved with CFS and eligible for DD services to identify trends and areas that may need the attention of both divisions.

### **Agency Response: Accept**

DHHS accepts this recommendation and has improved relationships and collaboration between the Division of Children and Family Services (DCFS) and the Division of Developmental Disabilities (DDD). DCFS and DDD participate on the Cross-Division Solution Team Weekly Meeting to discuss complex care cases that come to their attention. The Cross-Division Solution Team promotes an environment to collaborate, gain information regarding the responsibility and programs within each division and identify system issues.

In addition, DCFS and DDD participate monthly on the Children and Family Services/Developmental Disabilities Workgroup to improve communication and collaboration between the two divisions. Areas identified to improve are:

- Communication Regarding Reason for Denial
  - The State Ward Developmental Disability Services Eligibility Procedure Guide has been developed to give guidance to CFS and DD when an eligibility determination is being

requested for a DHHS state ward. This can be located at:

[http://dhhs.ne.gov/children\\_family\\_services/Documents/DDGuide.pdf](http://dhhs.ne.gov/children_family_services/Documents/DDGuide.pdf)

- Cross Training Between CFS and DD
  - CFS and DD have developed power points to train CFS Specialist and Service Coordinators. The power points are under final review and a plan will be put in place to train CFS Specialist and Service Coordinators early in the year.
- Guidance to CFS related to information necessary to make an eligibility determination within 90 days.
- Clarification to staff related to the similarities and differences between foster homes and enhanced family homes.
- Clarification regarding Guardian selection and who may be determined to be a conflict of interest.
- Consistent payment structure within CFS and DD when youth placed in enhanced family home or developmental disability group home.
- Funding options available to youth in the CFS system determined to be eligible for Developmental Disabilities.
- Educational needs of youth with developmental disabilities.

### **3. The Division of Developmental Disabilities should coordinate with Juvenile Probation to improve care to youth with developmental disabilities in the juvenile justice system.**

While limited, the available research suggests that youth with intellectual and developmental disabilities are overrepresented in the justice system, which is often ill-equipped to recognize and effectively work with these youth. One recent study estimated that 65 to 70 percent of justice involved youth can be classified as having a disability.<sup>63</sup>

Emails from DD staff and administrators revealed that they were confused about Probation's role and concerned about decisions that put him in detention or could lead to his placement at YRTC. Probation's lack of knowledge, training, and policy on youth with disabilities and the DD services available to youth on Probation, hampered the case.

Currently, there is little formal coordination between DD and Probation. For example, no data was available to the OIG on how many Probation youth had been deemed eligible for DD services, or how many had been prioritized for funding. No process for staffing difficult cases that the agencies share existed when the OIG conducted interviews in March through May of 2016.

The OIG recommends that DD and Probation begin to coordinate on shared cases and identify areas where they be able to partner to ensure that youth with developmental disabilities in the juvenile justice system are appropriately identified and served.

**Agency Response: Accept**

DHHS accepts this recommendation and will develop strategies in the future to promote DDD's coordination with Juvenile Probation to improve the care to youth with developmental disabilities in the juvenile justice system.

**OIG Comment:** There is no "Status Update" to give on the previous three recommendations because this was presented to the agency during the 2016 – 17 fiscal year. The status update for each will be provided in the 2017 OIG Annual Report.

## Investigation Summary:

### Deteriorating Conditions at the Youth Rehabilitation and Treatment Center – Kearney (YRTC-K)

During the 2015-16 fiscal year, the OIG experienced a more than 300 percent increase in complaints and critical incidents related to the Youth Rehabilitation and Treatment Center-Kearney (YRTC-K), Nebraska’s residential facility for young men in the juvenile justice system.

The escalation in critical incidents included an increase in escapes from the facility (from 29 in 2014-15 to 62 in 2015-16). The number of youth involved in other concerning incidents at YRTC-K also grew significantly. During the 2015-16 fiscal year, the OIG received: five reports of suicide attempts; 16 reports of self-harming behavior; 20 reports of assaultive or destructive behavior; and 11 reports of youth needing significant medical treatment. No such reports were received from YRTC-K during the year prior.

The OIG initially opened an investigation into the treatment being provided to five youth at the facility who were the frequent subject of complaints, reports of concerning incidents, or both.

Initial file reviews and evidence gathered revealed deeper issues, including widespread noncompliance with statute. The investigation was expanded to focus on the administrative oversight and decision-making that allowed a deterioration of conditions at YRTC-K to go unchecked for months while the facility was without a full-time administrator.

### Background on YRTC-K:

The state of Nebraska established the Girls and Boys Industrial School in Kearney (now the YRTC-K) in 1879. In 1892, the Kearney facility became an all-boys facility.

In 1994, Nebraska lawmakers created the Office of Juvenile Services as a separate division of the Department of Correctional Services, with a director appointed by the governor and charged with oversight of the two YRTCs. The Office of Juvenile Services was tasked with meeting and addressing the unique needs and developmental differences of youth. In 1997, the office – including the YRTCs – was transferred from corrections to the Department of Health and Human Services (DHHS).

YRTC-K is now part of DHHS’ Division of Children and Family Services. YRTC-K can house up to 172

young men and has an annual operating budget of approximately \$12.4 million.<sup>64</sup>

Since DHHS took over administration of YRTC-K, it has undergone significant changes, been the subject of media attention and public debate, and experienced significant impact from ongoing juvenile justice reform efforts.

Since 1998, the Office of Juvenile Services Act (Neb. Rev. Stat. § 43-401 to 43-424) has laid out a number of basic requirements for DHHS in regards to both YRTCs. For almost 20 years, Nebraska law has required that programming and treatment at the YRTCs address:

- Behavioral and mental health conditions and needs;
- Drug and alcohol addiction;



- Education and special education;
- Individual, group, and family therapy; and,
- Case management and structured programming aimed at reintegrating youth into their families, communities, and schools.

There has been regular debate on how best to serve the youth at the YRTCs.

LB 561, passed in 2013, placed new limits on admissions to the YRTCs and made major changes to the juvenile justice system. Since 2013, Nebraska law has required all community-based resources be exhausted before a judge can send a youth to a YRTC.<sup>65</sup> These changes contributed to the following population declines:

- Admissions declined from more than 400 in Fiscal Year 2011-12 to just 161 in 2014-15;
- Average daily population declined from 160 in 2011-12 to just 98 in 2014-15.<sup>66</sup>

In 2014, additional legislative changes directly impacted the YRTCs. LB 464 required that YRTCs develop and begin implementing evidence-based programming. Older youth who had formerly been prosecuted as adults were now staying in the juvenile justice system. These changes in the law also made it more difficult for youth who committed law violations at YRTC-K to be prosecuted as adults for escapes or minor assaults.<sup>67</sup>

Table I. Youth Files Reviewed as part of Investigation

Youth	Critical Incidents and Complaints
<b>A</b>	9 critical incidents – 3 escapes, 5 incidents of self-harm, 1 incident property destruction/staff assault
<b>B</b>	3 critical incidents – escapes; 3 complaints – inadequate medical care, lack of supervision by staff
<b>C</b>	2 critical incidents – 1 escape, 1 property destruction/staff assault
<b>D</b>	7 critical incidents – 3 suicide attempts, 2 escapes, 1 incident of self-harm, 1 staff assault
<b>E</b>	5 critical incidents– 1 suicide attempt, 4 incidents of self-harm; 2 complaints – lack of mental health services, lack of programming in Dickson Security Unit

After completing a review of all the paper files (classification, medical, mental health, and education) on the specific youth, the OIG identified systemic concerns that were impacting the facility. All of the youth whose files were reviewed were spending large amounts of time in the Dickson Security Unit. Some youth were there on safety status or for rule violations, though three of the five were assigned to secure care in

D5, a permanent housing unit in Dickson. Of the five youth, time in Dickson for safety status or rule violations went up to 66 days and time spent in D5 went up to over nine months, or 298 days.

## Investigative Findings:

*The decision to remove the prior facility administrator was made hastily and under outside pressure, without adequate consideration for the impact it might have on the youth and facility.*

On Sept. 16, 2015, DHHS announced that the YRTC-K Facility Administrator (FA) since 2009 was being transferred to Lincoln to work as a CFS liaison to coordinate between DHHS and Juvenile Probation. The FA had been informed of the decision on the evening of September 15.

The OIG investigation revealed that the decision to remove the YRTC-K FA occurred quickly – over a series of a few weeks. Interviews, emails, and personnel records did not suggest that there were concerns with the FA's performance. Instead, the decision seemed primarily based on concerns and pressure from outside DHHS, primarily from NAPE, the state employees union.

Email records of Central Office Administrators showed that the decision to remove the FA was made at the same time that NAPE was raising concerns about how the facility was operating. Just a week before the FA was removed, NAPE told Central Office administrators that it was planning a press release about concerns at the facility unless changes were made.

Emails indicate that NAPE believed incident reports were being modified by YRTC-K administration to keep the number of youth prosecuted as adults for crimes at the YRTC down. The OIG assisted the Ombudsman's office with looking into a similar allegation regarding modification of incident reports during the late fall of 2014 and found no evidence that there

was intentional changing of incidents to keep numbers low or to make data look better.

*No appropriate plan was in place for operations under interim administration.*

The OIG investigation found that five days before the former facility administrator was removed, DHHS had not yet developed a plan for how YRTC-K would be managed or how the search for the new facility administrator would occur.

The OIG found that YRTC-K was effectively without a full-time leader for seven months. Two days before the YRTC-K facility administrator was removed, Central Office Administration informed the FA for YRTC-Geneva that he would be managing both facilities on an interim basis. While this FA did his best to manage both facilities, it was not possible to do so. Shortly after being designated the FA at both facilities, a key staff member at YRTC-Geneva retired, making the task of overseeing both facilities more difficult. The interim FA was only able to be at the YRTC-K facility a day or two a week at most.

The OIG also found that the hiring process for a full-time FA at YRTC-K was slow. The position was not posted until November 2015, six weeks after the position became vacant. Final interviews were not conducted until March 2016, and the new administrator was not able to begin work until mid-April 2016. Nothing was done to change interim administration when the hiring process took a longer period of time or when there were indications that YRTC-K was experiencing significant problems.

**Key data measures worsened under interim administration.**

During the period of no full-time administrator, data on key measures at YRTC-K worsened significantly, reversing much of the progress that had been made before the former FA's removal.

For over a decade, YRTC-K has participated in Performance-based Standards (PbS), a national quality assurance and coaching program for juvenile correctional facilities that was launched in 1995 by the U.S. Department of Justice's Office of Juvenile Justice and Delinquency Prevention. Comprehensive reviews and analysis occur every six months and compare data at individual facilities on specific measures to national averages.

April 2015 was one of the most successful PbS reviews ever for YRTC-K, showing progress on a number of measures that the facility had been working on for some time. The facility posted some of its best scores ever on use of isolation, and staff and youth safety. However, with no full-time administrator from Sept. 15 through April 2016, this progress was almost completely erased (see Table II.)

<b>Table II. Key Performance-based Standards Scores at YRTC-K, April 2015 – April 2016</b>			
	April 2015	October 2015	April 2016
Outcome Measures Better than Field Average (out of 34)	28	21	13
Outcome Measures Better than Prior Data Collection (out of 34)	24	16	10
Order 9: Average duration of isolation, room confinement, and segregation/special management in hours.	7.97	30.41	49.16
Safety 12: Assaults on staff per 100 person-days of youth confinement.	0.037	0.376	0.818
Safety 11: Assaults and fights on youth per 100 person-days of youth confinement.	0.553	1.061	0.753

An analysis of critical incidents (escapes and other serious incidents at the facility) received by the OIG also points to growing issues during that time period. The OIG received 117 critical incidents during the 2015-16 fiscal year, compared to just 29 the year before, when YRTC-K had full-time administration. Of the 117 critical incidents during the past fiscal year, 71 occurred between Sept. 15 and April 2016.

The OIG also found that assaults and the workforce vacancy and turnover rates increased under interim administration.

***OJS Administrator was not able to fulfill his job duties related to YRTC-K, leaving the facility without appropriate oversight.***

Neb. Rev. Stat. 43-404 states that: “The Administrator of the Office of Juvenile Services [...] shall be responsible for the administration of the facilities and programs of the office.” When it comes to responsibility for YRTCs, Nebraska law further charges OJS with: managing and establishing policies; supervising employees; ensuring the data is collected and analyzed; monitoring commitments; and coordinating with other programs and services in the juvenile justice system.<sup>68</sup>

The Legislature created the full-time gubernatorial appointment of OJS Administrator in 1994. In 2007, a reorganization of DHHS made the OJS Administrator an appointee of the new CEO or their designee. However, the position remained full-time until 2013, when additional duties were added as some of DHHS’ juvenile justice duties were transferred to Probation.

The OIG investigation into conditions at YRTC-K revealed that the OJS Administrator had been assigned so many other duties and priorities (ranging from overseeing child support enforcement to policy development for all of CFS) that he was unable to effectively manage YRTC-K and fulfill DHHS’ statutory obligations. In January 2015, he was named interim director of the Division of Children and Family Services and later became Deputy Director of Policy and Regulatory Compliance and Office of Juvenile Services. With that change in title, he oversaw:

- Central office staff in charge of child protective services policy;
- Central office staff in charge of adult protective services policy;
- Central office staff in charge of economic assistance program policy;

- Child support enforcement staff statewide;
- Child Abuse and Neglect Hotline staff; and,
- Juvenile Services staff at Central Office and the YRTCs.

The OIG found that the OJS Administrator met with YRTC administrators intermittently (four times in calendar year 2015). The OJS Administrator was unaware of how little time the interim FA was able to spend at YRTC-K until February 2016, nearly six months into his time managing both facilities. Most interactions or requests of YRTC interim administrator from Central Office were prompted by inquiries from Senators or media attention.

The lack of time to fulfill key OJS job functions meant that conditions at YRTC-K were allowed to significantly deteriorate, without anyone at Central Office taking the time or making an attempt to correct the facility’s course.

***Central Office was unaware of unlawful programs and practices.***

The OIG found that Central Office administrators were unaware of the troubling developments at YRTC-K that were in direct violation of Nebraska law requiring structured, rehabilitative programming be offered to all youth at the facility.<sup>69</sup>

Beginning in 2014, YRTC-K remodeled the Dickson Security Unit with the goal of creating a full-time secure housing unit for particularly challenging youth. The former YRTC-K administrator shared that this was an attempt to build the “Level 5 Facility” for the highest risk kids, which had been recommended by the OJS subcommittee of the Children’s Commission.<sup>70</sup> The remodel was complete in the spring of 2015 and youth soon began to live full-time in a special wing of Dickson, called D5 or secure care,

where they were to receive programming and education.

A list provided by YRTC-K, shows that 14 youth were assigned or “re-classified” to D5 from May 2015 to June 2016. Of these, seven have since been discharged to the community, six directly from Dickson. On average, youth spent 132.5 days, or 4.3 months in secure care in Dickson. Five youth have spent more than 7 months (212 days) in D5.

When the OIG interviewed Central Office Administrators they did not know that youth were living full-time in Dickson. Those interviewed indicated they thought that Dickson was being used for short behavior management stays, ranging to a few weeks or a month at most. They were also unaware that there was limited to no programming in Dickson while the facility was without a full-time administrator.

The OIG also found that Central Administration gave approval for staff at YRTC-K to visit and take steps toward implementing programming from the Mendota Juvenile Treatment Center in Madison, Wisc. in D5, without fully understanding how the program functioned – using extended periods in solitary, restraint chairs, shackles, and chemical sprays to control youth behavior. Once the prior FA (who had expressed concerns with the Mendota model) was removed, staff moved forward with plans to implement the program. Had this program been fully implemented, it would not only have been a significant departure from YRTC-K policies and practices, but also would have violated standards.<sup>71</sup>

***Youth at YRTC-K, especially those living full-time in Dickson, were subject to conditions that were not in compliance with Nebraska law.***

The OIG found multiple instances where YRTC-K did not provide youth with required

programming, education, therapy and other mental health services. This noncompliance to Neb. Rev. Stat. §43-407 was especially evident and numerous in the treatment offered to youth who were permanently assigned to the D5 group in Dickson.

The OIG found that youth assigned to D5 were spending all day every day in their separate unit of Dickson for the entirety of their stay, once assigned. The OIG completed extensive interviews with YRTC-K administrators, staff and youth about programming in Dickson. Universally, the OIG received feedback that programming was practically non-existent. Youth could choose whether or not to attend school, group meetings happened rarely, and youth were occupied by watching TV or playing video games. Youth classified to D5 were offered only the most basic educational opportunities and could not complete coursework to obtain their diploma or GED since some classes, like science, were not offered for youth assigned to that unit. Although a number of youth had Individual Education Plans (IEPs), special education was not being provided.

One factor impacting programming in D5 was a failure to adequately staff the unit. When Dickson was split into separate wings, no additional staff were provided for the unit. The other factor that impacted programming was that staff were waiting for the Mendota program to be implemented and felt they could not serve youth in that unit until the Mendota model was fully implemented.

The OIG also found concerns with the mental health care provided to youth at YRTC-K. Youth with severe behaviors – either aggressive towards others, self-harming, or suicidal – end up spending significant amounts of time in Dickson, either in room confinement due to safety status or rule violations, or as part of D5.

However, these youth had the least consistent access to important mental health programming and individual therapy. Youth and staff shared concerns about some therapists not spending time with clients on a regular basis, missing therapy sessions, being inattentive to medication management concerns, and failing to respond in a crisis.

Nebraska law requires that by Jan. 1, 2016, both YRTCs be in the process of implementing evidence-based programming and policies at their facilities. While the OIG investigation was not a study on evidence-based practices at the YRTC-K, the OIG investigation quickly found that EQUIP, the program assessed as evidence-based that has been implemented at YRTC-K, was run sporadically, without fidelity, especially while the facility was without a full-time administrator.

## OIG Recommendations and Agency Responses

### 1. Make the OJS Administrator a Full-time Position

One of the OIG's major findings in this report of investigation is that the OJS Administrator was unable to fulfill job duties required by Nebraska law, in large part because he had been assigned so many unrelated tasks. The role of OJS Administrator was intended by the Legislature to be a major, full-time position, and until recently it was. Unfortunately, the job has evolved to the point where in the past 12 months, if not earlier, the title of OJS Administrator has effectively been in name only. Other job duties have taken precedence over effective management and supervision of the YRTCs, leaving Central Office with substantial gaps of knowledge related to what was occurring at the YRTC-K, unable to effectively plan to address a changing juvenile justice system and population, and unaware of serious problems and violations of law for months.

The OIG recommends that DHHS restore the OJS Administrator to a full-time position. DHHS Central Office must take a leadership role in ensuring that the law is followed, the rights of youth served at the YRTCs are respected, and long-term challenges, including the transformation of the YRTCs to meet a changing juvenile justice system, are addressed. Even with the recent transfer of OJS youth supervised in the community, DHHS plays a major role in the juvenile justice system. Its juvenile justice obligations should not be ignored. A full-time OJS Administrator will ensure that DHHS is meeting its legal obligations and planning for the future of YRTCs appropriately.

#### **Agency Response: Reject**

DHHS rejects this recommendation. DHHS takes the responsibilities and duties of the Office of Juvenile Services (OJS) Administrator very seriously. CFS leadership team was restructured in late 2015 to better address the needs and direction of the Division as well as the YRTC facilities. This realignment resulted in a more equalized span of control for the four Deputy Directors within CFS. Expanding the responsibilities to include Protection & Safety policy and Economic Assistance policy as well as Juvenile Services policy and operations, increases the opportunity for collaboration and coordination across CFS. The realignment also facilitated closer coordination among Juvenile Services, Protection and Safety, and the Office of

Juvenile Probation. Protection and Safety field staff and overall division policy collaborate with Juvenile Services on a daily basis.

Restructuring continues in each functional area to optimize the overall structure. Child support operations are being transitioned to Economic Assistance and will be finalized the week of July 25, 2016. The resource development function, which spans across all areas in CFS, is currently being evaluated to improve utilization and effectiveness across DHHS. This evaluation will lead to additional restructuring and reallocation of resources across the Division. The vacant Program Development Administrator position that reports to the Director was filled in July 2016. Filling this position will further shift responsibilities away from the OJS Administrator.

Beginning in April 2016, the OJS Administrator leads a daily conference call with participants from across DHHS (including the CEO, Director of CFS, HR, Communications, and the Division of Behavioral Health), and facility administrators from YRTC Kearney and Geneva.

The purpose of the call is to discuss the current facility status, review any critical incidents from the previous day, identify behavioral concerns and treatment options for specific youth at the facilities, and to problem solve and track action steps around various initiatives at the facilities that will have a direct impact on improving the overall culture at the facilities, improve staff policies, training, communication, organization and effectiveness, and improve the treatment program and individual growth and development for our youth.

Some recent accomplishments as a result of the daily conference calls include the following:

#### Security for the Youth, Staff and Community

- Increased Staffing
  - Improved staff-to-youth ratio.
  - Will add 12 Youth Program Specialists.
  - Added two positions to direct care of the youth (Youth Case Management and Living Unit Manager).
  - Moved youth in one living unit into another living unit for improved staff utilization.
- Staff on Perimeter - Two employees on physical light duty are stationed on opposite sides of the campus to watch for escapes.
- Uniforms - Standard clothing for all youth and staff will be used so they are easily discernable.
- KPD Notices - When an escape occurs, Kearney Police Department is notified immediately.
- GPS Anklets - We will start placing security anklets on youth who have escaped or who are aggressive when they are at off-campus visits and furloughs home.
- Radios - Will upgrade radios to digital increasing reliability of staff communication.
- Accountability - To reduce safety threats and ensure accountability, youth who have committed assault, escaped or who show a pattern of aggressiveness must undergo intensive behavioral planning before returning to a living unit from the security unit. The Facility Administrator must approve the plan.
- Policy/Procedure Reviews - Review each escape with staff to ensure that policies and procedures are followed and take corrective action when necessary.

- Community Advisory Board - The new Community Advisory Board is meeting with management and provides community input.
- ID Badges - Staff ID badges have been issued with only last names.

### Creating a Healthier YRTC Environment

- Food Portions - Increased food portions for evening meals and provide a snack after school for the youth.
- Calls Home - Doubled the number of paid phone calls home each month from two to four.
- Gas Vouchers - Increasing family contact by issuing and paying for gas vouchers so parents can visit their sons more often.
- Job Skills - Collaborating with the Dept. of Labor to help youth who have graduated to enhance their job training skills and develop career paths.
- Grievances - Ensure an unbiased grievance process so youth trust that their concerns are addressed.
- Treatment - Teachers are now on living unit treatment teams for a fully functional multidisciplinary team.
- Title I Teacher - A Title I teacher has been assigned to address specific educational needs for youth in Dickson.
- Mental Health - Collaborate with DHHS' Behavioral Health Division to ensure youths' mental health needs are met.
- Medical Visits - Ensure youth visits with the contracted medical doctor occur by requiring approval from the Facility Administrator before changes in scheduled appointments.

### Staff Retention

- Overtime - Use new staff (30-90 days) for overtime duties when they are determined ready.
- Shifts - Direct-care staff moved to specific shifts so they have consistent days off. •
- Focus Groups - Held 11 employee focus groups of all classes of employees to enhance communication.
- All-Staff Meetings - Increased the number of all-staff meetings with DHHS leadership to enhance communication.
- Surveys - Conduct exit surveys for staff and youth when they leave YRTC to identify trends and develop retention strategies.
- Training - Ensure a new employee's on-boarding experience develops an appropriate culture through training observations.
- On-Boarding - New employees are paired with supervisory staff during orientation to ensure successful on-boarding.
- Ads - Increased recruitment ads and social media posts to increase applicant pool.
- Scoring - Revised interview scoring to ensure qualified applicants are hired.
- Workers Comp - Conduct thorough reviews of workers compensation reports to ensure employees are returned to duty at appropriate time.



DHHS continues to evaluate how collaboration can be enhanced across all 24 hour treatment facilities in each DHHS division (including YRTC - Kearney and Geneva) and improved utilization of the OJS Administrator functions and responsibilities, consistent with state law. This evaluation continues with recommendations expected in late-summer or early-fall.

**OIG Comment:** The OIG cannot stress enough the importance of the OJS Administrator having adequate time to give vital quality oversight of and direction to Nebraska's two YRTCs and related juvenile programs.

At the current time, the position of OJS Administrator is vacant.

## 2. Close or Appropriately Restructure Full-time Secure Care Program in Dickson, D5

The D5, or secure care program, that classifies or reclassifies youth to live in Dickson full-time, has been replete with issues and violations of law. From the OIG's investigation, it appears that DHHS administrators at Central Office have been mostly unaware of this program's existence and specifics until recently. Although the new Facility Administrator almost immediately insisted on putting some basic programming into D5, the OIG believes it is unlikely that these initial steps will be able to fully address DHHS' statutory requirement to provide programming and treatment to, "assure appropriate reintegration of the juvenile to his or her family, school, and community," for all youth at YRTC, *especially* without adequate and stable staffing levels.

Youth in D5 in particular seem to be struggling and deteriorating while at YRTC-K, with many ending up in the adult correctional system or with ever-worsening mental health issues. Discharging straight to the community from being in a lockdown facility 24/7, brings up serious questions about whether youth in D5 can really re-enter their communities safely and prepared.

Finally, youth in D5 are not afforded the same rights as other youth at YRTC-K, which poses questions about the legality of the program. Youth are not sent to D5 by judges, but instead "reclassified" while at YRTC-K without an option to re-enter their group or to appeal their classification. This classification means limited access to rehabilitative opportunities, privileges, or experiences offered to other youth at the facility, even going to the library. It also means that youth are shackled anytime they leave the Dickson building and have limited opportunities to fully participate in educational programming.

Though conditions are improving for youth currently in D5 under the leadership of the new Facility Administrator, Central Office must assess D5 quickly and decide whether to shutter the permanent secure care use of the building or completely restructure the program and create adequate policies and procedures to ensure that youth rights are respected and rehabilitative services can be accessed.

### **Agency Response: Accept**

DHHS accepts this recommendation. The Dickson Security Unit program is a short-term intervention intended to stabilize youth, over a short period of time, who are having difficulty functioning on a living unit. Youth temporarily living in Dickson receive treatment, participate in activities, and are provided educational services, with the expectation that they will be reintegrated into a living unit before discharge back to the community.

Since April 2016, DHHS has been in the process of restructuring the program and services that take place within the Dickson Security Unit. As noted in your investigation, Dr. Jerry Van Winkle, a staff at YRTC was studying the Mendota Program as a potential modality for the Dickson Unit. It was determined that the Mendota Program would not be appropriate for a facility or living unit, with a mission to rehabilitate youth and prepare them to successfully re-enter their community. The Mendota Program is no longer being considered as a viable treatment option.

The following steps will be or have been taken to ensure that DHHS provides a full array of treatment services for all youth at YRTC-K, which includes a complete re-structuring of the use of the Dickson Security Unit:

- Dickson is no longer considered a full-time living unit;
- Morton living unit is currently being remodeled to enable orientation and sick bay youth to be removed from Dickson; and
- All youth who enter Dickson who pose a threat to themselves or others, now have individualized behavior management programs that ultimately allow the youth to return to their “normal” living unit.

The Officer for the Day (OD) is now assigned to be stationed in Dickson. This is the senior staff specialist who will be able to identify immediate resources in the event an intervention is necessary.

#### **Status Update: *Progress***

The OD is no longer assigned to Dickson because it is organizationally more feasible for ODs to office out of the main administration building. Staffing levels have been prioritized for Dickson. Instead of one therapist assigned to Dickson, there are now two — one for each wing. There are two case managers assigned to each wing. In addition, a Kearney West High School Title 1 teacher goes out to, and is working with, the Dickson youth several times per day.

### **3. Develop Continuous Quality Improvement Process Led by Central Office**

In order to better monitor and also improve the performance of the YRTCs, the OIG recommends that Central Office develop and lead a continuous quality improvement (CQI) process specifically for OJS and the YRTCs. Currently, the YRTCs collect a fair amount of data for Performance-*based* Standards and through other facility documentation, like rule violations, use of force forms, etc. However, this data is underutilized and has not been effectively incorporated into a process to manage the YRTCs and improve performance. For example, YRTC-K has had three Facility Improvement Plans through Performance-*based* Standards that have been open for over 5 years (Reducing Isolation, Staff Safety, and Youth Safety). It has been unable to close a single plan to this date. From the documents provided to the OIG, it looks like Central Office has had minimal involvement in ensuring progress is made on these plans, especially since the change in OJS Administrators.

The OIG firmly believes that if Central Office takes a role in ensuring sufficient data is gathered, analyzed, and used to provide the facility feedback, significant performance improvements will result. CFS has seen significant progress from implementing a CQI process related to Protection & Safety services. Expanding the successful approach to juvenile services is essential to quality service being provided and facility

issues being addressed. Furthermore, as YRTC-K attempts to implement evidence-based practices, data that is regularly reviewed will be essential to ensuring fidelity of practice and maintaining compliance with the law.

**Agency Response: Accept**

DHHS accepts this recommendation. DHHS has been exploring how to build a robust CQI process for OJS that is led by our Deputy Director in CFS over Research, Planning and Evaluation in conjunction with the OJS Administrator. Some of the initial steps have included:

- OJS providing a position within the Research, Planning, and Evaluation Unit to focus on OJS CQI initiatives;
- CFS working to further identify areas of improvement needed within our existing Performance Based Standards (PbS); and
- OJS Administrator Green is working with PbS to obtain additional access to PbS data via their website for CQI staff.

CFS has developed an internal dashboard to track key indicators and action steps. The initial key indicators include escapes, assaults on staff by youth, youth educational improvement (as measured at initial intake), life skills training, and youth recidivism rate.

**Status Update: *Progress***

#### **4. Develop and implement a comprehensive Strategic Staffing Plan in order to achieve appropriate staff to youth ratios while attracting and retaining qualified staff members for YRTC-K**

DHHS Central Administration should commit to, develop and implement -- as soon as practicable -- a comprehensive Strategic Staffing Plan for YRTC-K, to improve staff to youth ratios, identify the needs of the youth sent to the YRTC-K, and attract and retain competent staff members. This is imperative if youth to staff ratios are to improve, which is necessary for not only youth and staff safety, but for improvement in youth outcomes as well.

Changes to the YRTC-K youth population, such as more charges now being filed in juvenile court -- possibly older and potentially more difficult youth who might have formerly been sent to adult facilities now more likely to come to YRTC-K, should be examined and documented. This, along with a study of the needs, such as mental health needs, of the population going to the YRTC-K should be analyzed to fully understand how recent changes in the law have impacted YRTC-K's population. After gaining a thorough understanding of the youth population the YRTC-K is serving, an appropriate staffing plan can be developed.

The Strategic Staffing Plan, with the analysis of the types of youth entering the YRTC and the youths' needs at the facility, should be provided to all interested stakeholders and policy-makers.

The Staffing Plan should include an aggressive program to attract, train and retain qualified staff members for YRTC-K. In formulating this plan, DHHS should earnestly examine ways to increase wages at

YRTC-K, realizing that many of the jobs at the facility can be high-stress and potentially dangerous and that competition for qualified workers in the Kearney area is intense. Starting hourly pay for Staff Security Specialist II, for example, is \$14.41 an hour. The job description for a Staff Security Specialist II says: *“...supervise youth in daily and evening activities which includes school, recreation, and meal times, document behavior, **respond to crisis situations**, and serve as a role model to the youth. May be required to transport youth. Work will include physical stamina/strength, standing, walking, and occasional lifting and **the ability to physically intervene if needed.**”*

Kearney and Buffalo County have a population of less than 50,000 people. Even if the eight surrounding counties are added, the population is only around 200,000, according to U.S. Census data compiled by the Kearney Area Chamber of Commerce. YRTC-K is competing for a limited pool of workers with several major employers, including the University of Nebraska at Kearney, Good Samaritan Hospital, Baldwin Filters, Eaton Corporation, Morris Press, Marshall Engines, West Pharmaceutical Services, the Buckle, and Chief Agri/Industrial Division. Additionally, the new Veteran’s Home being built in Kearney, another 24-hour facility run by DHHS, will soon compete with YRTC-K for employees.

**Agency Response: Accept**

DHHS accepts this recommendation. As noted in your 2015 OIG Annual Report, DHHS has been working on a strategic staffing plan to meet the needs of the youth, to assure the safety of our youth, staff, community, and to comply with the Prison Rape Elimination Act (PREA) by October 1, 2017. In addition, the strategic staffing plan is part of a more comprehensive review of all YRTC operations. The review has highlighted an area in which DHHS has a significant need in terms of ensuring the facility has adequate staff to provide for the safety of our youth, staff and community. The minimum PREA staff requirements require ratios of 1:8 during waking hours and 1:16 during sleeping hours. Historically, YRTC facilities created staffing schedules within the living units to assure each living unit had a certain number of staff. This was not a needs based approach based on the number of youth in each living unit. As new staff are hired resources are being dedicated to the youth and needs of the facility. The current desired staffing analysis is below.

### YRTC-Kearney staffing analysis

AREA	YOUTH POPULATION	STAFF/YOUTH RATIO	TOTAL STAFF WITH 1.7 RELIEF
Creighton	20	1:8 day, 1:16 night	13.6
Lincoln	20	1:8 day, 1:16 night	13.6
Washington	20	1:8 day, 1:16 night	13.6
Bryant	20	1:8 day, 1:16 night	13.6
Morton	20	1:8 day, 1:16 night	13.6
Dickson – North (secure unit)	8	1:6 day, 1:8 night	8.5
Dickson – West (STEPS)	8	1:6 day, 1:12 night	8.5
Isolation/24 hr. control center	4	1:4 day, 1:4 night	5.1
Transportation	n/a	n/a	2
Rovers	n/a	n/a	2
			<b>TOTAL STAFF NEEDED : 94.1</b>

YRTC-K CURRENT TOTAL YOUTH POPULATION: 103      YRTC-K AVG. POPULATION: 105

YRTC-K CURRENT TOTAL YSS FUNDED POSITIONS: 55

YRTC-K YSS POSITIONS ADDED IN 05/16 WITHOUT THE NEED TO REQUEST ANY ADDITIONAL FUNDS: 12

TOTAL NUMBER OF POSITIONS THAT NEEDS TO BE REQUESTED FOR NEXT BIENNIUM BUDGET WITH A PRIMARY STAFF YOUTH RATIO OF 1:8 DAY, 1:16 NIGHT: 27 (94-55-12=27)

Status Update: *Progress*

## 5. Digitalize Records

To allow better and more timely monitoring of operations and identification of potential issues at YRTC-K, DHHS Central Administration should immediately work towards digitalizing all existing and future facility records (including but not limited to youth intakes and evaluations, critical incidents, therapy notes, grievances and living unit logs) to make things more efficient for YRTC-K staff and administrators and ensure that Central Administration and authorized entities have real-time access to such records. This would involve scanning existing and future paper records. The need for digitalization became apparent during the OIG’s investigation, when investigators made trips to YRTC-K to scan and email thousands of documents – which was a cumbersome, time-consuming process. It is hard to imagine how frustrating it must be for YRTC administrators and those overseeing the YRTCs at Central Office, with youth records being in paper copy only. The OIG recommends that DHHS Central Administration also consider moving to a system that would generate all documents electronically, making access to records faster and more transparent.

### Agency Response: **Accept**

DHHS accepts this recommendation and believes it would provide an ease of access not only for Central Office personnel, as well as others requiring access. DHHS is committed to ongoing discussions of how this might be accomplished.

**Status Update: *Incomplete***

No completion date has been set.

**OIG Comment:** It appears that Mark LaBouchardiere, who was named the new facility administrator in April 2016, has moved – with support from Central Administration – to address many of the problems and concerns at YRTC-K flagged by the OIG (such as eliminating plans to implement the Mendota Program).

More time is needed to assess the changes that have been and will be made at YRTC-K and to measure what improvements have been achieved.

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## Issue Spotlight

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# Parental Rights in Juvenile Justice Cases

Over the past year, the OIG has received several complaints from parents who have a son or daughter on juvenile probation, and placed out-of-home. Upon initial review, these cases did not rise to a level of any identified wrongdoing, but instead raise concerns about protecting the rights of parents in juvenile justice cases. Such cases show a need for improvement in the overall procedural protections for Nebraska parents regarding their right to custody.

Confusion arises when a parent's visitation is limited, for example; they do not feel heard or that they have a right to be heard. This brings up questions about what the parent's role is, and ultimately what the parent's rights are, when their child is involved in the juvenile justice system. Further, these parents generally do not have legal representation, as there have been no formal legal filing against them, and their child is not officially made a ward of the state.

### BACKGROUND

The Nebraska Juvenile Code distinguishes between how child welfare and juvenile justice cases operate in juvenile court, including provisions to ensure due process, parental and juvenile rights, and informing parties of the possible outcomes. There is a difference when it comes to the parent's role in each.

Child welfare cases allege incidents of abuse or neglect about *parents*, whether by fault or no fault. A child welfare adjudication means the child

or children are dependent, and they can become wards of the state and committed to the care, custody, and control of the Department of Health and Human Services (DHHS).<sup>72</sup> The parents are informed of their rights, including their right to an attorney, since their parental rights could be affected by legal custody of the child being placed with DHHS, and ultimately the possibility of losing parental rights.<sup>73</sup> The Nebraska Juvenile Code spells out how DHHS makes decisions for state wards in their care and custody.

Juvenile justice cases allege wrongdoing based on the *youth's* behavior — whether a criminal or traffic violation, or the youth is deemed uncontrollable or truant from school. Juvenile court judges have the authority to place youth under the supervision of the court or juvenile probation with the possibility of removing these youth from their home.<sup>74</sup>

Once the youth is placed out of the home, the parental custody rights have been altered and there may be restrictions placed on parental contact with their child.

### QUESTIONS

Questions arise when there is a juvenile justice case based on the actions of the youth, the youth is under juvenile probation supervision, and the youth is placed out of the familial home. The issue of true legal custody is questioned: What legal obligations does Probation have when a youth is placed under their supervision? What are their

obligations with regard to facilitating visits with parents? Do parents truly retain full legal custody? If not, what are the assurances that are or should be in place to protect parent's rights? Should parents have the right to legal counsel and the explicit right to appeal?

The following are four examples that illustrate how these parental custody questions arise within our current juvenile justice system. These have been brought to the OIG's attention from across Nebraska. The first three cases are solely juvenile justice cases, no child welfare case was filed.

#### SPECIFIC SCENARIOS

**Example 1:** A 12-year-old was placed on an indefinite term of probation (which could last until she turned 19) for being uncontrollable, using tobacco, and disturbing the peace. The youth was removed from the home and had various placements, such as detention and shelter, for violating the terms of probation. After eventually being placed back in the home, a Motion to Revoke Probation was filed and Probation requested an out of home placement because the father allegedly allowed the youth to consume alcohol and to have contact with another youth with whom probation restricted from having contact. The youth was placed with grandparents. The Juvenile Court ordered supervised visits with the father. The father attended the hearing, but was not given the formal opportunity to have counsel present or effectually respond to the allegations against him.

**Example 2:** Youth was adjudicated for possession of drug paraphernalia and marijuana and was placed on probation. The youth's parents had joint custody. The youth was placed in detention and then released to the father's sole custody. Probation limited the mother's visits with the youth. The mother reported seeing her child less than 10 hours a week. Probation additionally required that the youth be on lockdown and set specific curfews when the youth was at the mother's house. Probation did not require that that youth be on lockdown at the father's house and allowed the father to set the youth's curfew. The mother was not afforded an opportunity to formally be heard about affecting her joint custody of her child.

**Example 3:** Youth was adjudicated for tobacco use, driving with no operator's license, a stop light violation, theft, being uncontrollable, and possession of a controlled substance. The youth was placed on an indefinite term of probation. The Juvenile Court ordered the youth be placed temporarily at a shelter. The court maintained that the permanency objective was reunification and granted the mother reasonable visitation with the youth. Probation set the visitation schedule — eight hours every other week. The mother attended the hearing that resulted in the youth's placement at the shelter and was not represented by an attorney. There was no hearing to determine if the visitation schedule set by Probation was reasonable, and the mother had no formal opportunity to object.

**Example 4:** Youth was adjudicated as uncontrollable and for unauthorized use of a financial transaction device and placed on an indefinite term of probation. The youth was also under a child welfare case and made a ward of the state. The youth was placed in a foster home and then ran away. An Affidavit in Support of Placement at a staff secure facility filed by Probation made multiple references to the youth not having earned family time. The Affidavit noted that Probation did not



think it a good idea for the youth to have any family time when the youth was not following rules at school. Additionally, the foster parent was upset that the youth would receive family time. The mother had legal counsel in the child welfare case but was not represented in the youth's juvenile justice case. Probation's stance on visitation with the mother could have interfered with DHHS's requirement to set a visitation schedule on the child welfare case.

The examples above raise concerns about whether the system is giving adequate consideration to parental rights and due process protections in the custody decisions made for their children. This concern extends to the parents' access to reasonable visitation of their children while the parents retain legal custody. The parents in the examples said they felt that their parental rights were being disregarded. Further clarification on the extent of the Office of Probation's authority with regards to "care and placement responsibility" for adjudicated youth and clearly-defined procedural safeguards appear necessary.

Contacts to the OIG have led to the discovery of at least two instances where the Juvenile Court order assigned the Office of Probation "care, custody, and control" of the adjudicated child. Whether or not this was purposeful or simply old language that was used, it is unclear under the current applicable

statutes that the Office of Probation has the authority to have legal **custody** of the child. Is the result, in effect, making that youth a ward of the state?

When legal custody of the child is unclear, it presents concerns about who will make decisions about medical care, education, and the like, when necessary. Who is specifically tasked with effectively ensuring the child has visitation with parents, siblings or other family members? Clarification and defined parameters on what the Office of Probation's responsibilities and obligations are for adjudicated youth when placed on a term of probation is needed. Accordingly, parents that retain custody of adjudicated youth should be notified of their responsibilities and obligations to their child while the youth is under the Office of Probation's supervision and what parental rights may be affected.

# APPENDICES

# Appendix A: 2015-16 OIG Recommendations

## Recommendations to DHHS

During the 2015-16 fiscal year, the OIG made 26 recommendations to the Department of Health and Human Services (DHHS). DHHS accepted 25 of the recommendations and rejected one recommendation.

As of Aug. 15, 2016, an OIG review determined that:

- **Four** recommendations from last year have been fully implemented;
- **11** recommendations have had substantial progress towards implementation made; and,
- **Nine** recommendations remain entirely or mostly incomplete.

The chart below gives detailed information on each of the recommendations and their implementation status. The OIG continues to monitor the implementation of recommendations.

OIG Recommendation	Implementation Status
<p><b>Implement training on the medical aspects of child abuse, including information on:</b></p> <ul style="list-style-type: none"> <li>• <b>Distinguishing between accidental injuries and those that are more likely to be caused by abuse; and</b></li> <li>• <b>Working with medical professionals to obtain and document needed information on suspicious injuries or medical concerns.</b></li> </ul> <p>DHHS accepted on Sept. 8, 2015.</p>	<p><b>Progress</b></p> <p>In January 2016, the Center for Children Families and the Law (which contracts with DHHS), updated its “Introduction to Maltreatment” training for new workers, to include information on the medical aspects of child abuse.</p> <p>CCFL is also in the process of contracting with Dr. Suzanne B. Haney, a child abuse and neglect Pediatrician, for consultation regarding the relevant training delivered.</p>
<p><b>Adopt policy on photographing injuries during Initial Assessment.</b></p> <p>DHHS accepted on Sept. 8, 2015.</p>	<p><b>Complete</b></p> <p>In February 2016, DHHS adopted <a href="#">Program Memo #5-2016</a>, “Use of Photographs from Intake through Case Closure.” The memo requires that, “Photographs related to allegations of abuse or neglect will be placed into document imaging within 1 business day of receipt of the photographs.”</p> <p>The new policy requires caseworkers to use only state equipment to take and store photographs.</p>
<p><b>Develop additional training for Initial Assessment staff.</b></p> <p>DHHS accepted on Sept. 8, 2015.</p>	<p><b>Complete</b></p> <p>CCFL has updated its New Worker Training to include a more intensive focus on family engagement. Caseworker in-service training on Enhanced SDM Safety Planning, Engaging Families on Sensitive Subjects, Human Trafficking, Advanced Testifying, and Engaging Families in Safety and Risk Assessments have been developed and are offered around the state.</p>

<p><b>Further define process for utilizing child advocacy centers during Initial Assessment, when cases involve children who are difficult to interview such as those with:</b></p> <ul style="list-style-type: none"> <li>• Medical or psychological conditions;</li> <li>• Developmental delays;</li> <li>• Speech impairments; and,</li> <li>• Other situations where the child's situation does not lend to a successful "regular" law enforcement-type or Initial Assessment interview.</li> </ul> <p>DHHS accepted on Sept. 8, 2015.</p>	<p><b>No further action</b></p> <p>In July 2015, just before the OIG's recommendation, <a href="#">Program Memo #21-2015</a> providing specific criteria on when a child <i>must</i> be interviewed at a CAC was issued.</p> <p>DHHS reports that there is no policy that prevents other types of children from being interviewed at a CAC. On the advice of DHHS Legal, they will not update the current memo to add additional cases that should be considered for a CAC interview. Instead this decision will be left to local 1184 or multidisciplinary teams. This is to avoid placing the burden for referral on DHHS staff alone. Furthermore, rural CACs do not have forensic interviewers with special training to deal with many of the special cases the OIG recommended including.</p>
<p><b>Update and provide additional detail on response priority definitions.</b></p> <p>DHHS accepted on Sept. 8, 2015.</p>	<p><b>Incomplete</b></p> <p>DHHS is in the process of identifying areas where improvements are needed based on staff and medical feedback. An updated manual is expected to be issued by February 2017.</p>
<p><b>Conduct an analysis to determine whether supervisory staffing at the Hotline is adequate.</b></p> <p>DHHS accepted on Sept. 8, 2015.</p>	<p><b>Progress</b></p> <p>DHHS has made some changes to supervisory workload at the Hotline. In fall 2015, supervisors began reducing the number of reports accepted for assessment they reviewed. They continued to review all screened out reports.</p> <p>New supervisory workload guidelines at the hotline are expected to go into effect in September 2016.</p>
<p><b>Expand quality assurance (QA) and continuous quality improvement (CQI) at the Hotline.</b></p> <p>DHHS accepted on Sept. 8, 2015.</p>	<p><b>Incomplete</b></p> <p>In the fall of 2015, CQI staff began listening to randomly selected Hotline calls to assess their quality.</p> <p>However, CFS CQI staff currently review less than 200 randomly selected Hotline intakes a quarter to check for accuracy of screening decisions.</p>
<p><b>Increase the Initial Assessment (IA) workforce to comply with Nebraska law on caseload standards.</b></p> <p>DHHS accepted on Apr. 8, 2016.</p>	<p><b>Incomplete</b></p> <p>CFS is working towards increasing workforce stability by enhancing retention and filling vacancies in a timely manner. A number of non-case manager positions are being reviewed to explore whether repurposing of ancillary positions could be used as an option to improving compliance with caseload standards.</p>
<p><b>Take steps toward greater IA workforce specialization and experience.</b></p>	<p><b>Incomplete</b></p> <p>DHHS reports that individual Service Areas are developing plans to address and promote IA workforce specialization. However, due to the need to retain</p>

<p>DHHS accepted on Apr. 8, 2016.</p>	<p>flexibility in transferring from IA to ongoing case management, it is not possible to have a fully specialized IA workforce in most parts of the state.</p>
<p><b>Contract with an independent entity to perform a validation study of Nebraska’s SDM® Risk Assessment instrument.</b></p> <p>DHHS accepted on Apr. 8, 2016.</p>	<p><b>Progress</b></p> <p>DHHS has contracted with the National Council on Crime and Delinquency to conduct a validation analysis on the SDM® Risk Assessment. The study is set to begin in October 2016.</p>
<p><b>Improve Pediatric Abusive Head Trauma prevention efforts, by:</b></p> <ul style="list-style-type: none"> <li>• <b>Gathering and analyzing additional data on the prevalence of pediatric abusive head trauma; and</b></li> <li>• <b>Updating “shaken baby syndrome” materials distributed by the Division of Public Health.</b></li> </ul> <p>DHHS accepted on Apr. 8, 2016.</p>	<p><b>Progress</b></p> <p>CFS is participating in Child Safety Collaborative Innovation &amp; Improvement Network (CoIIN) led by the Children's Safety Network. Members of the team include the Division of Public Health and the Nebraska Children and Families Foundation.</p> <p>The CoIIN is developing an Abusive Head Trauma Prevention Took Kit which will include a sample model policy statement and updated materials for birthing hospitals. The results from the "All Birthing Hospital Wide Safe Sleep and Shaken Baby Survey" collected by the Division of Public Health in April 2015 are also being reviewed. CFS plans to add a "Coping with Crying" public service announcement to the radio schedule aired by the Nebraska Broadcaster's Association.</p>
<p><b>Increase CFS workforce ability to participate in pediatric abusive head trauma prevention efforts.</b></p> <p>DHHS accepted on Apr. 8, 2016.</p>	<p><b>Complete</b></p> <p>In April 2016, CFS Central Office distributed an “Under 2” packet, in English and Spanish, designed with input from the Division of Public Health, to field staff. Information about pediatric abusive head trauma is included in the packet.</p> <p>CFS Staff are encouraged to give out the information anytime they assess or work with a family with a very young child.</p>
<p><b>Improve supervision at the Child Abuse and Neglect Hotline, by:</b></p> <ul style="list-style-type: none"> <li>• <b>Increasing the number of supervisors; and</b></li> <li>• <b>Assessing Hotline staff workload and ongoing training.</b></li> </ul> <p>DHHS accepted on Apr. 8, 2016.</p>	<p><b>Incomplete</b></p> <p>New supervisory review expectations will go into effect at the hotline in September 2016. However, DHHS has no plans to increase the number of supervisors at this point.</p>
<p><b>Enhance availability of data on Initial Assessment and mixed caseloads:</b></p>	<p><b>Incomplete</b></p>

<ul style="list-style-type: none"> <li>• <b>At the administrative level, for use in decision making Central Office; and</b></li> <li>• <b>To the public on an ongoing, preferably monthly basis.</b></li> </ul> <p>DHHS accepted on Apr. 8, 2016.</p>	<p>The CFS Quality Assurance team is currently testing a new caseload/workload methodology for case assignments, which will likely be available in the Spring of 2016.</p> <p>DHHS reports that data of Child Welfare League of America caseload compliance are run on a regular basis. However, reports are only made public once a year in a report to the Legislature.</p>
<p><b>Collect data on high and very-high risk cases that do not accept services and implement more promising approaches to family engagement.</b></p> <p>DHHS accepted on Apr. 8, 2016.</p>	<p><b>Incomplete</b></p> <p>CFS is planning on developing a new data report in 2017 that collects and stratify data on families determined to be high or very high risk by SDM.</p>
<p><b>Restructure the Children’s Justice Act (CJA) taskforce.</b></p> <ul style="list-style-type: none"> <li>• <b>Ensure there is a work focused on improving child abuse investigations occurring.</b></li> <li>• <b>Enhance monitoring on how CJA funds are spent to ensure address systemic gaps in child abuse investigations.</b></li> </ul> <p>DHHS accepted on Apr. 8, 2016.</p>	<p><b>Progress</b></p> <p>DHHS is developing a process to improve monitoring of CJA funds. In July 2016, CJA billing was modified to an expense reimbursement document, which will require those receiving funds to provide documentation on how the funds were spent.</p> <p>The Nebraska Commission for the Protection of Children plans to create a separate working group or sub-committee to work on improvements to multidisciplinary teams.</p>
<p><b>Adopt policy and procedure on checking infant sleep areas and asking about safe sleep in child welfare cases.</b></p> <p>DHHS accepted on Apr. 28, 2016.</p>	<p><b>Progress</b></p> <p>The Division of Public Health is finalizing a Safe Sleep Environment Checklist by October 2016. CFS expects that it will added into its policy by the end of 2016.</p>
<p><b>Enhance training, resources, and education available on infant safe sleep to staff, parents, and caregivers in child welfare cases.</b></p> <p>DHHS accepted on Apr. 28, 2016.</p>	<p><b>Complete</b></p> <p>An “under 2 packet” with information about safe sleep was created with assistance from the Division of Public Health and distributed in April 2016. Staff have been directed to use and distribute to all families they work with who have a child under 2.</p> <p>In July 2016, safe sleep information was included in New Worker Training.</p>

<p><b>Revise regulations to require child care center training before granting a provisional license.</b></p> <p>DHHS accepted on Apr. 28, 2016.</p>	<p><b>Incomplete</b></p> <p>Public Health reports that is going to move forward with a revision of the regulations for all licensed child care programs in the next 18 months. Public Health will recommend that the training regarding safe sleep practices, shaken baby prevention, and child abuse/neglect reporting training be required before the issuance of a license.</p> <p>This recommendation will need to be approved through the regulation promulgation process, so implementation is not guaranteed.</p>
<p><b>Adopt policies and procedures on mental and behavioral health care as soon as possible.</b></p> <p>DHHS accepted on Mar. 1, 2016.</p>	<p><b>Progress</b></p> <p>In April 2016, DHHS adopted <a href="#">Program Memo #11-2016</a> which designates caseworkers as the party responsible to: “</p> <ol style="list-style-type: none"> <li>1. Provide informed consent or denial to the prescription of psychotropic medications;</li> <li>2. Coordinate and share information with the medical provider, dental provider, behavioral health provider, the parent(s), and any out-of-home care provider that may be delivering service to children/youth (Reference Program Guidance Memo #18-2015, "Medical, Dental, and Vision Exams for State Wards"); and</li> <li>3. Monitor and routinely review the effectiveness of psychotropic medications.”</li> </ol> <p>The memo contains a new Psychotropic Medication Informed Consent form that must be used and requires supervisory consultation any time a youth is prescribed three or more psychotropic medications. The memo also provides guidance on how and when caseworkers should check on the effectiveness of psychotropic medications and coordinate with professionals about mental health concerns.</p> <p>DHHS expects to adopt policy on mental health and trauma screening later in the fall of 2016.</p>
<p><b>Enhance efforts to reduce caseworker turnover.</b></p> <p>DHHS accepted on Mar. 1, 2016.</p>	<p><b>Progress</b></p> <p>In January 2016, DHHS developed a data report to better track turnover and vacancies.</p> <p>In April 2016, DHHS developed a realistic job preview for those applying for positions to improve appropriate recruitment.</p> <p>In May 2016, DHHS developed training for supervisors, with the hope of better supporting caseworkers and improving retention.</p>
<p><b>Make the OJS Administrator a Full-time Position.</b></p> <p>DHHS rejected on Aug. 1, 2016.</p>	<p>DHHS rejected this recommendation.</p>

	In August 2016, the CFS Deputy Director for Policy and Regulatory Compliance and Office of Juvenile Services resigned their post. The position of OJS Administrator is currently vacant.
<p><b>Close or Appropriately Restructure D5, the Secure Care Program housed in Dickson at YRTC-K.</b></p> <p>DHHS accepted on Aug. 1, 2016.</p>	<p><b>Progress</b></p> <p>DHHS no longer considers Dickson a full-time living unit and is focusing on restructuring the programming by:</p> <ul style="list-style-type: none"> <li>• Remodeling Morton living unit to enable orientation and sick bay youth to be removed from Dickson.</li> <li>• Ensuring youth entering Dickson who pose a threat to themselves or others, now have individualized behavior management programs that ultimately allow the youth to return to their “normal” living unit.</li> <li>• Increasing staffing levels for both wings, including more mental health staff, case managers, and Title 1 teacher visits.</li> </ul>
<p><b>Develop Continuous Quality Improvement (CQI) Process for YRTC-K Led by Central Office.</b></p> <p>DHHS accepted on Aug. 1, 2016.</p>	<p><b>Progress</b></p> <p>DHHS has created a new position in the Research, Planning, and Evaluation Unit to focus on OJS CQI initiatives. It is also working to identify areas for improvement within the existing Performance Based Standards.</p> <ul style="list-style-type: none"> <li>• CFS is developing an internal data dashboard to track key YRTC indicators, including escapes, assaults on staff by youth, youth educational improvement (as measured at initial intake), life skills training, and youth recidivism rate.</li> </ul>
<p><b>Develop and Implement a Strategic Plan for staffing YRTC-K.</b></p> <p>DHHS accepted on Aug. 1, 2016.</p>	<p><b>Progress</b></p> <p>DHHS has calculated how many staff it needs for YRTC-K to comply with staffing ratios established in the Prison Rape Elimination Act.</p>
<p><b>Digitalize Records at YRTC-K.</b></p> <p>DHHS accepted on Aug. 1, 2016.</p>	<p><b>Incomplete</b></p> <p>DHHS is committed to discussing how this recommendation could be implemented.</p>
<p><b>Adopt policy on Joint case management and case planning with Juvenile Probation</b></p> <p>Recommendation issued &amp; accepted in FY 16-17</p>	<p><b>Planned Action for 16/17</b></p> <p>DHHS has been working with the Administrative Office of Probation to develop a Crossover Youth Collaborative Guide. The guide is scheduled to be fully implemented in the spring of 2017.</p>
<p><b>Increase training and coordination between CFS and DD</b></p> <p>Recommendation issued &amp; accepted in FY 16-17</p>	<p><b>Planned Action for 16/17</b></p> <p>The Cross-Division Solution Team Weekly Meeting discusses complex care cases, of which CFS and DD are active participants. The Children and Family Services/Developmental Disabilities Workgroups meets monthly to improve communication and collaboration between the two divisions.</p>
<p><b>Coordinate DD with Juvenile Probation</b></p> <p>Recommendation issued &amp; accepted in FY 16-17</p>	<p><b>Planned Action for 16/17</b></p> <p>DHHS will promote DD’s coordination with Juvenile Probation.</p>



## Recommendations to the Administrative Office of Probation

During the 2015-16 fiscal year, the OIG made four recommendations to the Administrative Office of Probation (Probation).

OIG Recommendation	Implementation Status
<p><b>Adopt training and policy on supervising youth with intellectual and developmental disabilities (I/DD).</b></p> <p>Probation rejected on June 30, 2016.</p>	<p>Probation rejected the report.</p>
<p><b>Adopt policy on child welfare referrals and joint case management with DHHS.</b></p> <p>Probation rejected on June 30, 2016.</p>	<p>Probation rejected the report.</p>
<p><b>Adopt policy on documentation and record keeping.</b></p> <p>Probation rejected on June 30, 2016.</p>	<p>Probation rejected the report.</p>
<p><b>Increase internal quality assurance efforts at the state level.</b></p> <p>Probation rejected on June 30, 2016.</p>	<p>Probation rejected the report.</p>

# APPENDIX B: 2014-15 OIG RECOMMENDATIONS

During the 2014-2015 fiscal year, the OIG made 14 recommendations to the Department of Health and Human Services (DHHS). Of those, DHHS accepted 13 of the recommendations and requested modification of one. At the time of last year’s annual report, none of the recommendations had been fully implemented.

As of Aug. 15, 2016, an OIG review determined that:

- **Five** recommendations from last year have been fully implemented;
- **Six** recommendations have had substantial progress towards implementation made; and,
- **Three** recommendations remain mostly incomplete.

The chart below gives detailed information on each of last year’s recommendations and their implementation status.

OIG Recommendation	Implementation Status
<p><b>Adopt federally mandated mental &amp; behavioral health policies</b>, including those on:</p> <ul style="list-style-type: none"> <li>• Use and oversight of psychotropic medications (informed consent process, mandatory review of special cases, compliance monitoring)</li> <li>• Mental health and trauma screening and treatment(health screening protocol, identification of needs in case plan)</li> <li>• Guidelines on sharing and updating of medical information</li> </ul> <p>DHHS accepted on Jan. 23, 2015.</p>	<p><b>Progress</b></p> <p>DHHS has not yet adopted policy on mental health and trauma screening. They expect to adopt a tool for screening in the fall of 2016.</p> <p>Policy was adopted on psychotropic medications and medical coordination.</p> <p>In April 2016, DHHS adopted <a href="#">Program Memo #11-2016</a> which designates caseworkers as the party responsible to: “</p> <ol style="list-style-type: none"> <li>1. Provide informed consent or denial to the prescription of psychotropic medications;</li> <li>2. Coordinate and share information with the medical provider, dental provider, behavioral health provider, the parent(s), and any out-of-home care provider that may be delivering service to children/youth (Reference Program Guidance Memo #18-2015, "Medical, Dental, and Vision Exams for State Wards"); and</li> <li>3. Monitor and routinely review the effectiveness of psychotropic medications.”</li> </ol> <p>The memo also contains a new Psychotropic Medication Informed Consent form that must be used and requires supervisory consultation any time a youth is prescribed three or more psychotropic medications.</p> <p>The memo also provides guidance on how and when caseworkers should check on the effectiveness of psychotropic medications and coordinate with professionals about mental health concerns.</p>

<p><b>Expand training on mental and behavioral health</b></p> <ul style="list-style-type: none"> <li>• Ensure all DHHS staff have training</li> <li>• Develop guides and provide information to medical professionals and youth placements</li> <li>• Review training content to ensure suicide, developmental disabilities, and psychotropic medication are covered adequately</li> </ul> <p>DHHS accepted on Jan. 23, 2015.</p>	<p><b>Progress</b></p> <p>The Center for Children, Families, and the Law (CCFL), which provides training for DHHS, hired a mental health content expert who is responsible to review, update and deliver training specific to Psychotropic Medication, informed consent, Trauma Informed Care and the Prevention of Suicide.</p> <p>Mental health training for new workers continues to be updated to reflect new research and DHHS policy. Recent revisions occurred in February, June, and August 2016. Training tips from these trainings are available to all staff.</p> <p>Additional training on psychotropic medication is currently in development and will be made available to all staff.</p>
<p><b>Expand quality improvement and assurance related to mental and behavioral health and psychotropic medications</b></p> <p>DHHS accepted on Jan. 23, 2015.</p>	<p><b>Complete</b></p> <p>DHHS updated its NFOCUS system in March 2015 to allow data on medications, health care appointments, and medical conditions to be entered.</p> <p>Data entered is now reviewed by administration and at Continuous Quality Improvement (CQI) meetings.</p> <p>In August 2016, a monthly data report will be automated on all children/youth prescribed more than 3 psychotropic medications, to enhance oversight.</p>
<p><b>Improve Home Study Process</b></p> <ul style="list-style-type: none"> <li>• Adopt uniform, standardized home study process and questionnaires</li> <li>• Create additional mandatory fields for home studies on relative and kinship homes</li> <li>• Expand quality assurance and improvement processes related to home studies</li> </ul> <p>DHHS requested modification on Mar. 24, 2015. The OIG issued a modified recommendation (above) on Apr. 14, 2015.</p>	<p><b>Incomplete</b></p> <p>DHHS adopted a new home study format and issued a guidebook in January 2014. While DHHS believes this format is sufficient, the OIG continues to recommend the adoption of a standardized home study process and questionnaires.</p> <p>Currently, there is no quality assurance process for home studies. DHHS is currently developing a process where Resource Development Foster Care Supervisors will conduct reviews of random samples of licensing files, including home studies.</p> <p>In March 2015, DHHS adopted <a href="#">Program Memo #9-2015</a>, which required specific information be gathered on kinship and relative homes in the home study process, including on the relationship between the home and the child’s parent(s), and any special needs the home might have.</p>
<p><b>Provide stronger supports for kinship and relative families</b></p> <ul style="list-style-type: none"> <li>• Develop a protocol for providing supports to kinship families in all service areas</li> </ul>	<p><b>Progress</b></p> <p>In December 2015, DHHS adopted <a href="#">Program Memo #33-2015</a>, which clarifies the roles of caseworkers and Resource Development workers in supporting foster homes, including kinship and relative, that are not supported by a private agency.</p>

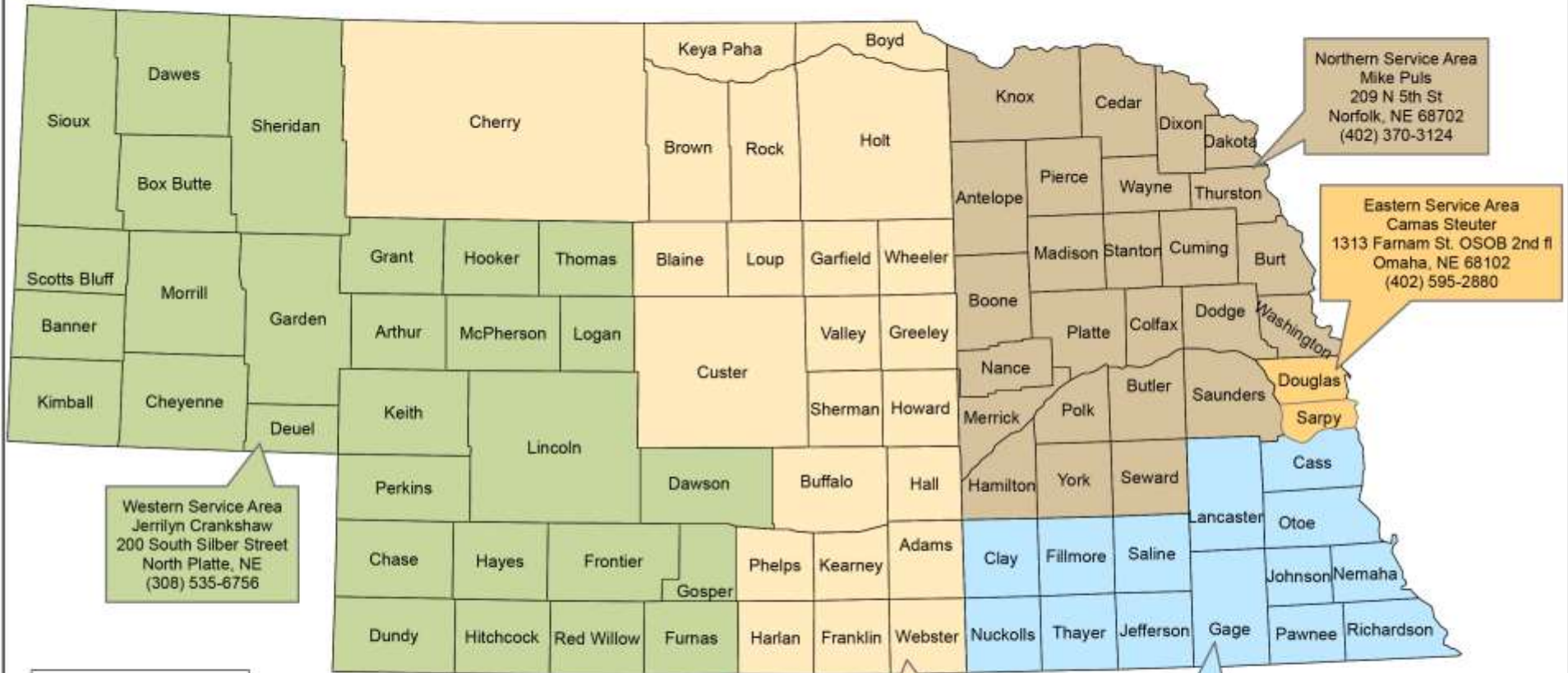
<ul style="list-style-type: none"> <li>Expand availability of kinship-specific resources and training</li> </ul> <p>DHHS accepted on Mar. 24, 2015.</p>	<p>Each CFS Service Area has adopted a process for kinship and relative homes to choose to be supported by a private foster care agency of their choice or DHHS.</p> <p>Kinship-specific training and resources remain limited. Some private foster care agencies have provided specific one-on-one trainings to kinship foster homes. The Nebraska Foster and Adoptive Parent Association (NFAPA) is developing a training called “Kin-nect Orientation.”</p>
<p><b>Ensure “Absence of Maltreatment in Foster Care” data measure is as accurate as possible</b></p> <p>DHHS accepted on Mar. 24, 2015.</p>	<p><b>Complete</b></p> <p>Since May 2016, DHHS lists the number of maltreatment cases that have been “court pending” between 8 and 12 months in its CQI reports. This better captures cases of maltreatment that may not be counted in the federal measure because they are awaiting court action, usually because the crime is particularly serious.</p>
<p><b>Develop and provide training to frequent reporters and law enforcement on Child Abuse and Neglect Hotline.</b> Specifically provide information on:</p> <ul style="list-style-type: none"> <li>Definition of abuse and neglect</li> <li>When to report cases that do not meet definition</li> <li>Information to include in child abuse reports</li> </ul> <p>DHHS accepted on June 8, 2015.</p>	<p><b>Progress</b></p> <p>In the fall of 2015, the League of Municipalities distributed DVD training modules on child abuse and neglect reporting and investigations to local law enforcement agencies. DHHS assisted with the production of the module on how the hotline works and what information it needs.</p> <p>No training for other frequent reporters – schools, medical professionals, etc. – has been yet been produced.</p>
<p><b>Create a protocol for asking for and receiving photos at the child abuse and neglect hotline.</b></p> <p>DHHS accepted on June 8, 2015.</p>	<p><b>Complete</b></p> <p>In February 2016, DHHS adopted <a href="#">Program Memo #5-2016</a>:</p> <p>“During the course of gathering information the Intake CFS Specialist will ask if photographs exist of the alleged injuries and or home conditions described in the report. If the reporting party has photographs the Intake CFS Specialist will request that the photos be emailed to the hotline mailbox.</p> <p>A. The photographs will be put into Document Imaging in the restricted category under the name of the alleged victim.</p> <p>B. The intake will clearly state that the photographs were provided by the reporting party and have been loaded into N-FOCUS.”</p>
<p><b>Assess availability of training, information, and programs designed to prevent child abuse within immigrant and limited English proficient communities.</b></p>	<p><b>Incomplete</b></p> <p>DHHS and its prevention partners have yet to begin an assessment of child abuse prevention resources available to Nebraska’s immigrant and limited English proficient populations.</p>

<p>DHHS accepted on June 8, 2015.</p>	<p>DHHS reports that they have partnered with the Nebraska Child Abuse Prevention Fund Board and the 2016 Bring Up Nebraska Campaign, both administered by the Nebraska Children and Families Foundation, to host 18 Community Cafés that Spanish-speaking parents could attend and print child abuse prevention posters and banners in Spanish.</p>
<p><b>Adopt and implement standards for transporting youth to and from YRTCs</b></p> <p>DHHS accepted on July 27, 2015.</p>	<p><b>Incomplete</b></p> <p>DHHS Resource Development Staff are working with transportation providers to develop and implement standard contracts.</p> <p>A draft contract is being submitted to DHHS legal for review soon. DHHS anticipates transportation contracts going into place by October 2016, for providers who wish to sign the contract.</p>
<p><b>Increase and improve resources, tools, and support for the Prison Rape Elimination Act (PREA) implementation at YRTC-Geneva.</b></p> <ul style="list-style-type: none"> <li>• Increase Central Office oversight of and support for PREA efforts</li> <li>• Better engage YRTC-Geneva staff in PREA implementation</li> <li>• Revise and expand staff and youth training on PREA and sexual abuse</li> </ul> <p>DHHS accepted on July 27, 2015.</p>	<p><b>Complete</b></p> <p>In July 2015, a full-time Central Office PREA Manager position was created to oversee PREA implementation at both YRTCs. The position now reports to the Juvenile Justice Collaboration Program Manager.</p> <p>The PREA Manager position became vacant in June 2016, but DHHS is currently in the hiring process.</p> <p>PREA Compliance Managers at both facilities now report to the statewide PREA Manager, instead of facility administrators.</p>
<p><b>Provide increased guidance for culture change at YRTC-Geneva</b></p> <p>DHHS accepted on July 27, 2015.</p>	<p><b>Progress</b></p> <p>DHHS has created additional Central Office Positions that have responsibilities related to YRTC, including the PREA Manager and Juvenile Justice Collaboration Program Manager.</p>
<p><b>Make clarifications to policies governing sexual abuse and harassment at YRTC-Geneva</b></p> <p>Including coordinating with Law Enforcement, notifying Hotline of reports; reporting abuse, harassment, assault; and preserving evidence</p> <p>DHHS accepted on July 27, 2015.</p>	<p><b>Complete</b></p> <p>In August 2015, DHHS updated Administrative Regulation 115.17 to clarify reporting of incidents, investigation protocol, training, and other PREA-related topics.</p> <p>YRTC-Geneva made changes to OM 115.17.5 in August 2015 to clarify facility-specific policy and procedure.</p>
<p><b>Clarify hotline procedure when receiving a report of sexual assault from YRTC-Geneva</b></p> <p>DHHS accepted on July 27, 2015.</p>	<p><b>Progress</b></p> <p>Hotline Administrator and Field Operations Manager reviewed policy and procedures with staff.</p> <p>An OIG review of recent hotline intakes involving YRTC-Geneva showed that some errors continued to be related to notifying the appropriate law enforcement agency. The Hotline Administrator issued additional reminders to staff in August 2016 and will continue to monitor these reports and correct staff when appropriate.</p>

## Appendix C:

# DHHS Service Area Map and Probation District Map

# CFS Service Areas Protection and Safety

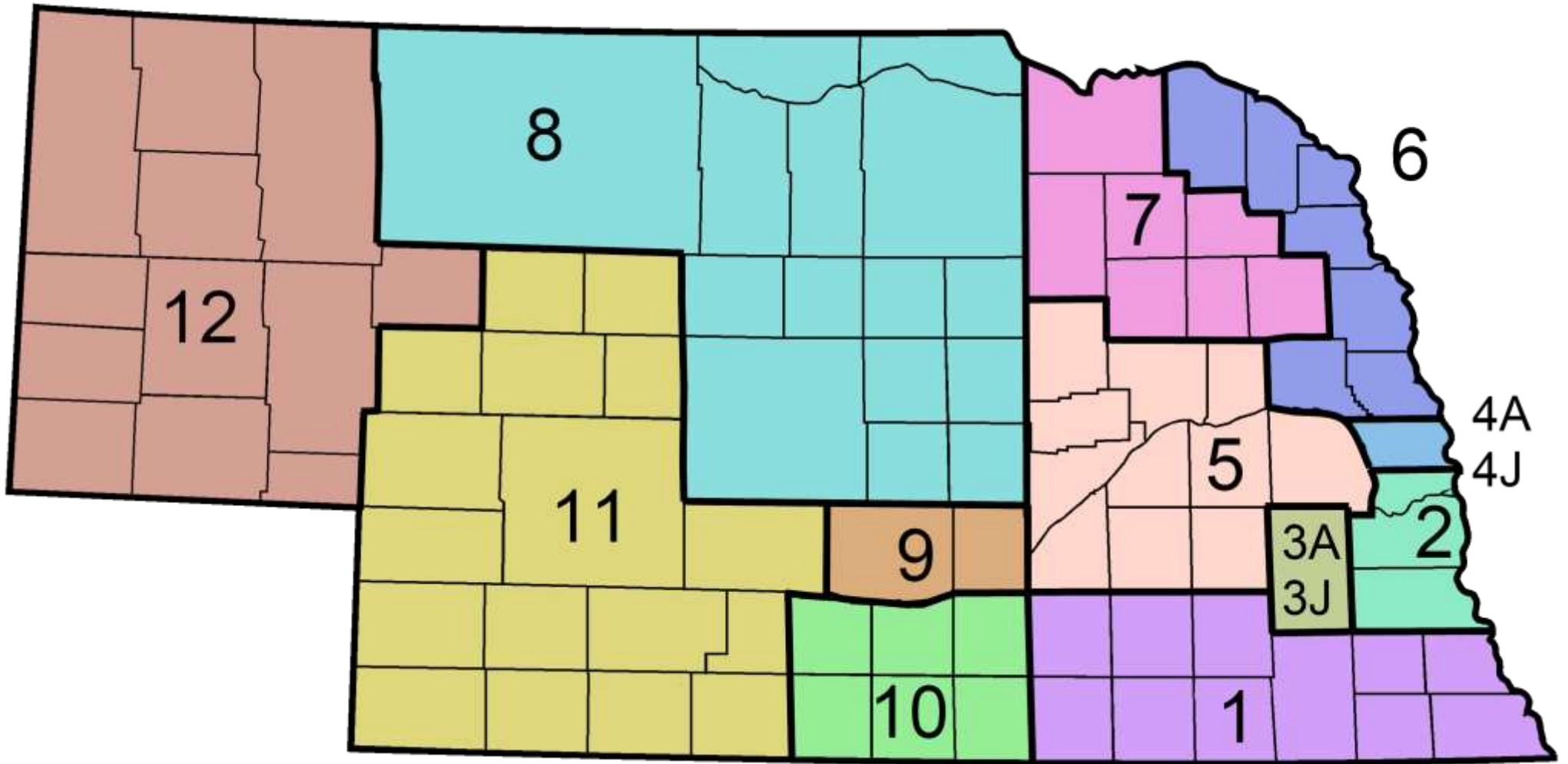


## Legend

- Western
- Central
- Southeast
- Eastern
- Northern

0 50 100 Miles

# Probation District Map





# Appendix D: Juvenile Room Confinement Data Guide

Nebraska lawmakers passed LB 894 into law during the 2016 session. Among the issues the bill addressed, LB 894 created new requirements for juvenile facilities (including residential child-caring agencies, secure and staff secure juvenile detention facilities, facilities within the Department of Correctional Services that house youth under the age of majority, and youth rehabilitation and treatment centers) to track and report the use of room confinement for juveniles. (The specific language of the relevant statutes can be found in below.)

Neb. Rev. Stat. §83-4,134.01 requires that juvenile facilities document juveniles in room confinement for longer than one hour. It also provides that data on room confinement be collected and submitted to the Nebraska Legislature on a quarterly basis then reviewed by the OIG. The first such quarterly report is due October 15, 2016. The OIG is required to analyze the information and report findings annually.

To start this new process, the OIG created a guide for data tracking so that entities across the state will be reporting uniform data points. Included in these guidelines are requirements for how data on room confinement is collected and reported.

## Definitions

In collecting data about juvenile room confinement under the requirements of Neb. Rev. Stat. § 83-4,134.01, definitions should be used as follows:

**“Juvenile”** means a person younger than 19 years of age.

**“Juvenile facility”** means a residential child-caring agency, a juvenile detention facility or staff-secure facility, a facility operated by the Department of Correctional Services that houses youth under age 19, or a youth rehabilitation and treatment center.<sup>75</sup>

**“Ethnicity”** refers to one of the following:

- Hispanic/Latino
- Not Hispanic/Latino

**“Race”** refers to one or more of the following:

- American Indian/Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Multi-Race – Please indicate up to 3 if this category is chosen

**“Room confinement”** means the involuntary restriction of a juvenile alone in a locked or unlocked cell, room, or other area—including a juvenile’s own room, except during normal sleeping hours—with minimal or no contact with persons other than facility staff and attorneys.

“Except during normal sleeping hours” shall only apply to the “juvenile’s own room” within the general population of the juvenile facility. The exception for normal sleeping hours does not include any special unit, cell, room, building, or area where the juvenile is room-confined.

Note: For example, if a youth is taken at 19:00 to a unit away from his/her own regular sleeping room for room confinement and stays for 48 hours, the count would be 48 hours, not 48 hours minus sleeping hours.

**“Time placed in room confinement” & “Time removed from room confinement”** will utilize a 24-hour clock with midnight being 0:00, noon being 12:00, and one minute before midnight being 23:59.

**“Supervisory approval”** means the name of staff who provides a signature for approval, who has supervision duties over the staff making the initial decision for room confinement longer than an hour.

**“Total hours in confinement”** means rounding up to the nearest quarter hour.

Note: For example, if the juvenile was in room confinement from 13:14 to 18:51, the total hours would be 5.75 hours.

Note: If an attempt to return the juvenile to the general population is unsuccessful, the time in confinement does not restart. For example, if a staff member made an attempt to return a juvenile to the general population and within one-half hour was unsuccessful, the time in confinement would resume where it left off, not restart at zero.

**“Reason for room confinement”** means one of the following:

- The juvenile has a medical issue
- The juvenile poses a serious and immediate danger to others
  - Physically assaulted another youth
  - Physically assaulted staff
  - Verbally abusive towards another youth
  - Verbally abusive towards staff
  - Sexually assaulted another youth
  - Sexually assaulted staff
- The juvenile has committed a behavioral infraction or rule violation
- The juvenile poses a serious and immediate danger to themselves due to self-harming behavior
- The juvenile poses a serious and immediate danger to themselves due to threat of suicide
- The juvenile poses a serious and immediate danger to themselves due to suicide attempt
- The juvenile is an imminent escape risk
- The juvenile is committing a substantial destruction of property
- Confinement is necessary for the juvenile’s safety and protection from another
- The juvenile is the only youth or gender at the facility and by reason of being the only one, has contact with just facility staff
- Institutional or administrative reason – head count
- Institutional or administrative reason other than head count
- The facility has had an escape
- The facility has had a riot
- It is mandatory rest or nap time
- The juvenile is having a meal alone

**“Staffing levels at time of confinement”** refers to all direct-care personnel (any care staff member charged with day-to-day supervision of juveniles housed in a juvenile detention facility) staffing ratios in the unit at the time of room confinement.

\*For facilities that are campus-based or have more than one unit, please provide staffing (direct-care personnel) ratios for both the unit *and* the building/campus, which will be separate categories on the form.

**“Attempts to return the juvenile to the general population of the facility were unsuccessful”** includes the following:

- The juvenile still poses a serious and immediate danger to others
- The juvenile still poses a serious and immediate danger to themselves due to self-harming behavior
- The juvenile still poses a serious and immediate danger to themselves due to threat of suicide
- The juvenile still poses a serious and immediate danger to themselves due to suicide attempt
- The juvenile is sleeping because it is during regular sleeping hours
- The results of the physical/medical clinical evaluation completed recommended continued room confinement.
- The results of the mental health clinical evaluation completed recommended continued room confinement.
- The juvenile is in continued need to be protected from another

**“Self-Harming”** refers to intentionally injuring her or himself.

**“Suicide”** means death caused by self-directed injurious behavior with an intent to die as a result of the behavior.

**“Suicide Attempt”** refers to a non-fatal, self-directed, potentially injurious behavior with an intent to die as a result of the behavior; might not result in injury.<sup>76</sup>

**“Evaluation”** means a physical or mental health clinical evaluation completed by a credentialed medical or mental health professional.

**“Corrective measures”** means action taken after a staff does not comply with Neb. Rev. Stat. § 83-4,134.01.

## Submitting Reports & Due Dates

1. Reports shall be uploaded on the Nebraska Legislature’s website
2. Data shall be emailed to [OIG@leg.ne.gov](mailto:OIG@leg.ne.gov)

Quarterly reporting begins 2 weeks after the quarter ending September 30, 2016.

Submissions are expected on or before:

**October 15**

**January 15**

**April 15**

**July 15**

If a facility has no occurrence of juvenile room confinement during a quarter, the facility is expected to submit a report stating such.

## Juvenile Room Confinement Statutes

### **83-4,125. Detention and juvenile facilities; terms, defined.**

For purposes of sections 83-4,124 to 83-4,134.01:

(1) Criminal detention facility means any institution operated by a political subdivision or a combination of political subdivisions for the careful keeping or rehabilitative needs of adult or juvenile criminal offenders or those persons being detained while awaiting disposition of charges against them. Criminal detention facility does not include any institution operated by the Department of Correctional Services. Criminal detention facilities shall be classified as follows:

(a) Type I Facilities means criminal detention facilities used for the detention of persons for not more than twenty-four hours, excluding nonjudicial days;

(b) Type II Facilities means criminal detention facilities used for the detention of persons for not more than ninety-six hours, excluding nonjudicial days; and

(c) Type III Facilities means criminal detention facilities used for the detention of persons beyond ninety-six hours;

(2) Juvenile detention facility means an institution operated by a political subdivision or political subdivisions for the secure detention and treatment of persons younger than eighteen years of age, including persons under the jurisdiction of a juvenile court, who are serving a sentence pursuant to a conviction in a county or district court or who are detained while waiting disposition of charges against them. Juvenile detention facility does not include any institution operated by the department;

(3) Juvenile facility means a residential child-caring agency as defined in section 71-1926, a juvenile detention facility or staff secure juvenile facility as defined in this section, a facility operated by the Department of Correctional Services that houses youth under the age of majority, or a youth rehabilitation and treatment center;

(4) Room confinement means the involuntary restriction of a juvenile to a cell, room, or other area, alone, including a juvenile's own room, except during normal sleeping hours; and

(5) Staff secure juvenile facility means a juvenile residential facility operated by a political subdivision (a) which does not include construction designed to physically restrict the movements and activities of juveniles who are in custody in the facility, (b) in which physical restriction of movement or activity of juveniles is provided solely through staff, (c) which may establish reasonable rules restricting ingress to and egress from the facility, and (d) in which the movements and activities of individual juvenile residents may, for treatment purposes, be restricted or subject to control through the use of intensive staff supervision. Staff secure juvenile facility does not include any institution operated by the department.

### **83-4,134.01. Juvenile facility; legislative intent; placement in room confinement; provisions applicable; report; Inspector General of Nebraska Child Welfare; duties.**

(1) It is the intent of the Legislature to establish a system of investigation and performance review in order to provide increased accountability and oversight regarding the use of room confinement for juveniles in a juvenile facility.

(2) The following shall apply regarding placement in room confinement of a juvenile in a juvenile facility:

(a) Room confinement of a juvenile for longer than one hour shall be documented and approved in writing by a supervisor in the juvenile facility. Documentation of the room confinement shall include the date of the occurrence; the race, ethnicity, age, and gender of the juvenile; the reason for placement of the juvenile in room confinement; an explanation of why less restrictive means were unsuccessful; the ultimate duration of the placement in room confinement; facility staffing levels at the time of confinement; and any incidents of self-harm or suicide committed by the juvenile while he or she was isolated;

(b) If any physical or mental health clinical evaluation was performed during the time the juvenile was in room confinement for longer than one hour, the results of such evaluation shall be considered in any decision to place a juvenile in room confinement or to continue room confinement;

(c) The juvenile facility shall submit a report quarterly to the Legislature on the number of juveniles placed in room confinement; the length of time each juvenile was in room confinement; the race, ethnicity, age, and gender of each juvenile placed in room confinement; facility staffing levels at the time of confinement; and the reason each juvenile was placed in room confinement. The report shall specifically address each instance of room confinement of a juvenile for more than four hours, including all reasons why attempts to return the juvenile to the general population of the juvenile facility were unsuccessful. The report shall also detail all corrective measures taken in response to noncompliance with this section. The report shall be delivered electronically to the Legislature. The initial quarterly report shall be submitted within two weeks after the quarter ending on September 30, 2016. Subsequent reports shall be submitted for the ensuing quarters within two weeks after the end of each quarter; and

(d) The Inspector General of Nebraska Child Welfare shall review all data collected pursuant to this section in order to assess the use of room confinement for juveniles in each juvenile facility and prepare an annual report of his or her findings, including, but not limited to, identifying changes in policy and practice which may lead to decreased use of such confinement as well as model evidence-based criteria to be used to determine when a juvenile should be placed in room confinement. The report shall be delivered electronically to the Legislature on an annual basis.

# Appendix E: Office of Inspector General of Nebraska Child Welfare

In 2012, the Nebraska Legislature enacted the Office of Inspector General of Nebraska Child Welfare Act, the state law creating the OIG and authorizing its activities.

## [43-4301. Act, how cited.](#)

Sections 43-4301 to 43-4331 shall be known and may be cited as the Office of Inspector General of Nebraska Child Welfare Act.

## [43-4302. Legislative intent.](#)

(1) It is the intent of the Legislature to:

- (a) Establish a full-time program of investigation and performance review to provide increased accountability and oversight of the Nebraska child welfare system;
- (b) Assist in improving operations of the Nebraska child welfare system;
- (c) Provide an independent form of inquiry for concerns regarding the actions of individuals and agencies responsible for the care and protection of children and youth in the Nebraska child welfare system. Confusion of the roles, responsibilities, and accountability structures between individuals, private contractors, branches of government, and agencies in the current system make it difficult to monitor and oversee the Nebraska child welfare system; and
- (d) Provide a process for investigation and review to determine if individual complaints and issues of investigation and inquiry reveal a problem in the child welfare system, not just individual cases, that necessitates legislative action for improved policies and restructuring of the child welfare system.

(2) It is not the intent of the Legislature in enacting the Office of Inspector General of Nebraska Child Welfare Act to interfere with the duties of the Legislative Auditor or the Legislative Fiscal Analyst or to interfere with the statutorily defined investigative responsibilities or prerogatives of any officer, agency, board, bureau, commission, association, society, or institution of the executive branch of state government, except that the act does not preclude an inquiry on the sole basis that another agency has the same responsibility. The act shall not be construed to interfere with or supplant the responsibilities or prerogatives of the Governor to investigate, monitor, and report on the activities of the agencies, boards, bureaus, commissions, associations, societies, and institutions of the executive branch under his or her administrative direction.

## [43-4303. Definitions; where found.](#)

For purposes of the Office of Inspector General of Nebraska Child Welfare Act, the definitions found in sections 43-4304 to 43-4316 apply.

### [43-4304. Administrator, defined.](#)

Administrator means a person charged with administration of a program, an office, or a division of the department or administration of a private agency or licensed child care facility, the probation administrator, or the executive director.

### [43-4304.01. Child welfare system, defined.](#)

Child welfare system means public and private agencies and parties that provide or effect services or supervision to system-involved children and their families.

### [43-4304.02. Commission, defined.](#)

Commission means the Nebraska Commission on Law Enforcement and Criminal Justice.

[43-4305. Department, defined.](#)

Department means the Department of Health and Human Services.

[43-4306. Director, defined.](#)

Director means the chief executive officer of the department.

[43-4306.01. Executive director, defined.](#)

Executive director means the executive director of the commission.

[43-4307. Inspector General, defined.](#)

Inspector General means the Inspector General of Nebraska Child Welfare appointed under section 43-4317.

[43-4307.01. Juvenile services division, defined.](#)

Juvenile services division means the Juvenile Services Division of the Office of Probation Administration.

[43-4308. Licensed child care facility, defined.](#)

Licensed child care facility means a facility or program licensed under the Child Care Licensing Act, the Children's Residential Facilities and Placing Licensure Act, or sections 71-1901 to 71-1906.01.

[43-4309. Malfeasance, defined.](#)

Malfeasance means a wrongful act that the actor has no legal right to do or any wrongful conduct that affects, interrupts, or interferes with performance of an official duty.

[43-4310. Management, defined.](#)

Management means supervision of subordinate employees.

[43-4311. Misfeasance, defined.](#)

Misfeasance means the improper performance of some act that a person may lawfully do.

[43-4312. Obstruction, defined.](#)

Obstruction means hindering an investigation, preventing an investigation from progressing, stopping or delaying the progress of an investigation, or making the progress of an investigation difficult or slow.

[43-4313. Office, defined.](#)

Office means the office of Inspector General of Nebraska Child Welfare and includes the Inspector General and other employees of the office.

[43-4314. Private agency, defined.](#)

Private agency means a child welfare agency that contracts with the department or the Office of Probation Administration or contracts to provide services to another child welfare agency that contracts with the department or the Office of Probation Administration.

[43-4315. Record, defined.](#)

Record means any recording, in written, audio, electronic transmission, or computer storage form, including, but not limited to, a draft, memorandum, note, report, computer printout, notation, or message, and includes, but is not limited to, medical records, mental health records, case files, clinical records, financial records, and administrative records.

[43-4316. Responsible individual, defined.](#)

Responsible individual means a foster parent, a relative provider of foster care, or an employee of the department, the juvenile services division, the commission, a foster home, a private agency, a licensed child care facility, or another provider of child welfare programs and services responsible for the care or custody of records, documents, and files.

**43-4317. Office of Inspector General of Nebraska Child Welfare; created; purpose; Inspector General; appointment; term; certification; employees; removal.**

(1) The office of Inspector General of Nebraska Child Welfare is created within the office of Public Counsel for the purpose of conducting investigations, audits, inspections, and other reviews of the Nebraska child welfare system. The Inspector General shall be appointed by the Public Counsel with approval from the chairperson of the Executive Board of the Legislative Council and the chairperson of the Health and Human Services Committee of the Legislature.

(2) The Inspector General shall be appointed for a term of five years and may be reappointed. The Inspector General shall be selected without regard to political affiliation and on the basis of integrity, capability for strong leadership, and demonstrated ability in accounting, auditing, financial analysis, law, management analysis, public administration, investigation, or criminal justice administration or other closely related fields. No former or current executive or manager of the department may be appointed Inspector General within five years after such former or current executive's or manager's period of service with the department. Not later than two years after the date of appointment, the Inspector General shall obtain certification as a Certified Inspector General by the Association of Inspectors General, its successor, or another nationally recognized organization that provides and sponsors educational programs and establishes professional qualifications, certifications, and licensing for inspectors general. During his or her employment, the Inspector General shall not be actively involved in partisan affairs.

(3) The Inspector General shall employ such investigators and support staff as he or she deems necessary to carry out the duties of the office within the amount available by appropriation through the office of Public Counsel for the office of Inspector General of Nebraska Child Welfare. The Inspector General shall be subject to the control and supervision of the Public Counsel, except that removal of the Inspector General shall require approval of the chairperson of the Executive Board of the Legislative Council and the chairperson of the Health and Human Services Committee of the Legislature.

**43-4318. Office; duties; law enforcement agencies and prosecuting attorneys; cooperation; confidentiality.**

(1) The office shall investigate:

(a) Allegations or incidents of possible misconduct, misfeasance, malfeasance, or violations of statutes or of rules or regulations of:

(i) The department by an employee of or person under contract with the department, a private agency, a licensed child care facility, a foster parent, or any other provider of child welfare services or which may provide a basis for discipline pursuant to the Uniform Credentialing Act;

(ii) Subject to subsection (2) of this section, the juvenile services division by an employee of or person under contract with the juvenile services division, a private agency, a licensed facility, a foster parent, or any other provider of juvenile justice services;

(iii) The commission by an employee of or person under contract with the commission related to programs and services supported by the Nebraska County Juvenile Services Plan Act, the Community-based Juvenile Services Aid Program, juvenile pretrial diversion programs, or inspections of juvenile facilities; and

(iv) A juvenile detention facility and staff secure juvenile facility by an employee of or person under contract with such facilities;



(b) Death or serious injury in foster homes, private agencies, child care facilities, juvenile detention facilities, staff secure juvenile facilities, and other programs and facilities licensed by or under contract with the department or the juvenile services division; and

(c) Death or serious injury in any case in which services are provided by the department or the juvenile services division to a child or his or her parents or any case involving an investigation under the Child Protection and Family Safety Act, which case has been open for one year or less and upon review determines the death or serious injury did not occur by chance.

The department, the juvenile services division, each juvenile detention facility, and each staff secure juvenile facility shall report all cases of death or serious injury of a child in a foster home, private agency, child care facility or program, or other program or facility licensed by the department or inspected through the commission to the Inspector General as soon as reasonably possible after the department or the Office of Probation Administration learns of such death or serious injury. For purposes of this subsection, serious injury means an injury or illness caused by suspected abuse, neglect, or maltreatment which leaves a child in critical or serious condition.

(2) With respect to any investigation conducted by the Inspector General pursuant to subdivision (1)(a) of this section that involves possible misconduct by an employee of the juvenile services division, the Inspector General shall immediately notify the probation administrator and provide the information pertaining to potential personnel matters to the Office of Probation Administration.

(3) Any investigation conducted by the Inspector General shall be independent of and separate from an investigation pursuant to the Child Protection and Family Safety Act. The Inspector General and his or her staff are subject to the reporting requirements of the Child Protection and Family Safety Act.

(4) Notwithstanding the fact that a criminal investigation, a criminal prosecution, or both are in progress, all law enforcement agencies and prosecuting attorneys shall cooperate with any investigation conducted by the Inspector General and shall, immediately upon request by the Inspector General, provide the Inspector General with copies of all law enforcement reports which are relevant to the Inspector General's investigation. All law enforcement reports which have been provided to the Inspector General pursuant to this section are not public records for purposes of sections 84-712 to 84-712.09 and shall not be subject to discovery by any other person or entity. Except to the extent that disclosure of information is otherwise provided for in the Office of Inspector General of Nebraska Child Welfare Act, the Inspector General shall maintain the confidentiality of all law enforcement reports received pursuant to its request under this section. Law enforcement agencies and prosecuting attorneys shall, when requested by the Inspector General, collaborate with the Inspector General regarding all other information relevant to the Inspector General's investigation. If the Inspector General in conjunction with the Public Counsel determines it appropriate, the Inspector General may, when requested to do so by a law enforcement agency or prosecuting attorney, suspend an investigation by the office until a criminal investigation or prosecution is completed or has proceeded to a point that, in the judgment of the Inspector General, reinstatement of the Inspector General's investigation will not impede or infringe upon the criminal investigation or prosecution. Under no circumstance shall the Inspector General interview any minor who has already been interviewed by a law enforcement agency, personnel of the Division of Children and Family Services of the department, or staff of a child advocacy center in connection with a relevant ongoing investigation of a law enforcement agency.

**43-4319. Office; access to information and personnel; investigation.**

(1) The office shall have access to all information and personnel necessary to perform the duties of the office.

(2) A full investigation conducted by the office shall consist of retrieval of relevant records through subpoena, request, or voluntary production, review of all relevant records, and interviews of all relevant persons.

(3) For a request for confidential record information pursuant to subsection (5) of section 43-2,108 involving death or serious injury, the office may submit a written request to the probation administrator. The record information shall be provided to the office within five days.

**43-4320. Complaints to office; form; full investigation; when.**

(1) Complaints to the office may be made in writing. The office shall also maintain a toll-free telephone line for complaints. A complaint shall be evaluated to determine if it alleges possible misconduct, misfeasance, malfeasance, or violation of a statute or of rules and regulations pursuant to section 43-4318. All complaints shall be evaluated to determine whether a full investigation is warranted.

(2) The office shall not conduct a full investigation of a complaint unless:

- (a) The complaint alleges misconduct, misfeasance, malfeasance, or violation of a statute or of rules and regulations pursuant to section 43-4318;
- (b) The complaint is against a person within the jurisdiction of the office; and
- (c) The allegations can be independently verified through investigation.

(3) The Inspector General shall determine within fourteen days after receipt of a complaint whether it will conduct a full investigation. A complaint alleging facts which, if verified, would provide a basis for discipline under the Uniform Credentialing Act shall be referred to the appropriate credentialing board under the act.

(4) When a full investigation is opened on a private agency that contracts with the Office of Probation Administration, the Inspector General shall give notice of such investigation to the Office of Probation Administration.

**43-4321. Cooperation with office; when required.**

All employees of the department, the juvenile services division as directed by the juvenile court or the Office of Probation Administration, or the commission, all foster parents, and all owners, operators, managers, supervisors, and employees of private agencies, licensed child care facilities, juvenile detention facilities, staff secure juvenile facilities, and other providers of child welfare services or juvenile justice services shall cooperate with the office. Cooperation includes, but is not limited to, the following:

- (1) Provision of full access to and production of records and information. Providing access to and producing records and information for the office is not a violation of confidentiality provisions under any law, statute, rule, or regulation if done in good faith for purposes of an investigation under the Office of Inspector General of Nebraska Child Welfare Act;
- (2) Fair and honest disclosure of records and information reasonably requested by the office in the course of an investigation under the act;
- (3) Encouraging employees to fully comply with reasonable requests of the office in the course of an investigation under the act;
- (4) Prohibition of retaliation by owners, operators, or managers against employees for providing records or information or filing or otherwise making a complaint to the office;
- (5) Not requiring employees to gain supervisory approval before filing a complaint with or providing records or information to the office;
- (6) Provision of complete and truthful answers to questions posed by the office in the course of an investigation; and
- (7) Not willfully interfering with or obstructing the investigation.

**43-4322. Failure to cooperate; effect.**

Failure to cooperate with an investigation by the office may result in discipline or other sanctions.

**43-4323. Inspector General; powers; rights of person required to provide information.**

The Inspector General may issue a subpoena, enforceable by action in an appropriate court, to compel any person to appear, give sworn testimony, or produce documentary or other evidence deemed relevant to a matter under his or her inquiry. A person thus required to provide information shall be paid the same fees and travel allowances and shall be accorded the same privileges and immunities as are extended to witnesses in the district courts of this state and shall also be entitled to have counsel present while being questioned.

**43-4324. Office; access to records; subpoena; records; statement of record integrity and security; contents; treatment of records.**

(1) In conducting investigations, the office shall access all relevant records through subpoena, compliance with a request of the office, and voluntary production. The office may request or subpoena any record necessary for the investigation from the department, the juvenile services division as permitted by law, the commission, a foster parent, a licensed child care facility, a juvenile detention facility, a staff secure juvenile facility, or a private agency that is pertinent to an investigation. All case files, licensing files, medical records, financial and administrative records, and records required to be maintained pursuant to applicable licensing rules shall be produced for review by the office in the course of an investigation.

(2) Compliance with a request of the office includes:

- (a) Production of all records requested;
- (b) A diligent search to ensure that all appropriate records are included; and
- (c) A continuing obligation to immediately forward to the office any relevant records received, located, or generated after the date of the request.

(3) The office shall seek access in a manner that respects the dignity and human rights of all persons involved, maintains the integrity of the investigation, and does not unnecessarily disrupt child welfare programs or services. When advance notice to a foster parent or to an administrator or his or her designee is not provided, the office investigator shall, upon arrival at the departmental office, bureau, or division, the private agency, the licensed child care facility, the juvenile detention facility, the staff secure juvenile facility, or the location of another provider of child welfare services, request that an onsite employee notify the administrator or his or her designee of the investigator's arrival.

(4) When circumstances of an investigation require, the office may make an unannounced visit to a foster home, a departmental office, bureau, or division, a licensed child care facility, a juvenile detention facility, a staff secure juvenile facility, a private agency, or another provider to request records relevant to an investigation.

(5) A responsible individual or an administrator may be asked to sign a statement of record integrity and security when a record is secured by request as the result of a visit by the office, stating:

- (a) That the responsible individual or the administrator has made a diligent search of the office, bureau, division, private agency, licensed child care facility, juvenile detention facility, staff secure juvenile facility, or other provider's location to determine that all appropriate records in existence at the time of the request were produced;
- (b) That the responsible individual or the administrator agrees to immediately forward to the office any relevant records received, located, or generated after the visit;
- (c) The persons who have had access to the records since they were secured; and

(d) Whether, to the best of the knowledge of the responsible individual or the administrator, any records were removed from or added to the record since it was secured.

(6) The office shall permit a responsible individual, an administrator, or an employee of a departmental office, bureau, or division, a private agency, a licensed child care facility, a juvenile detention facility, a staff secure juvenile facility, or another provider to make photocopies of the original records within a reasonable time in the presence of the office for purposes of creating a working record in a manner that assures confidentiality.

(7) The office shall present to the responsible individual or the administrator or other employee of the departmental office, bureau, or division, private agency, licensed child care facility, juvenile detention facility, staff secure juvenile facility, or other service provider a copy of the request, stating the date and the titles of the records received.

(8) If an original record is provided during an investigation, the office shall return the original record as soon as practical but no later than ten working days after the date of the compliance request.

(9) All investigations conducted by the office shall be conducted in a manner designed to ensure the preservation of evidence for possible use in a criminal prosecution.

**43-4325. Reports of investigations; distribution; redact confidential information; powers of office.**

(1) Reports of investigations conducted by the office shall not be distributed beyond the entity that is the subject of the report without the consent of the Inspector General.

(2) Except when a report is provided to a guardian ad litem or an attorney in the juvenile court pursuant to subsection (2) of section 43-4327, the office shall redact confidential information before distributing a report of an investigation. The office may disclose confidential information to the chairperson of the Health and Human Services Committee of the Legislature or the chairperson of the Judiciary Committee of the Legislature when such disclosure is, in the judgment of the Public Counsel, desirable to keep the chairperson informed of important events, issues, and developments in the Nebraska child welfare system.

(3) Records and documents, regardless of physical form, that are obtained or produced by the office in the course of an investigation are not public records for purposes of sections 84-712 to 84-712.09. Reports of investigations conducted by the office are not public records for purposes of sections 84-712 to 84-712.09.

(4) The office may withhold the identity of sources of information to protect from retaliation any person who files a complaint or provides information in good faith pursuant to the Office of Inspector General of Nebraska Child Welfare Act.

**43-4326. Department; provide direct computer access.**

(1) The department shall provide the Public Counsel and the Inspector General with direct computer access to all computerized records, reports, and documents maintained by the department in connection with administration of the Nebraska child welfare system.

(2) The commission shall provide the Inspector General with direct computer access to all computerized records, reports, and documents maintained in connection with administration of juvenile justice services.

(3) The juvenile services division, as directed by the juvenile court or the Office of Probation Administration, shall provide the Inspector General with direct computer access to all computerized records, reports, and documents maintained by the juvenile services division in connection with a specific case under investigation.

**43-4327. Inspector General's report of investigation; contents; distribution.**

(1) The Inspector General's report of an investigation shall be in writing to the Public Counsel and shall contain recommendations. The report may recommend systemic reform or case-specific action, including a recommendation for discharge or discipline of employees or for sanctions against a foster parent, private agency, licensed child care facility, or other provider of child welfare services or juvenile justice services. All

recommendations to pursue discipline shall be in writing and signed by the Inspector General. A report of an investigation shall be presented to the director, the probation administrator, or the executive director within fifteen days after the report is presented to the Public Counsel.

(2) Any person receiving a report under this section shall not further distribute the report or any confidential information contained in the report. The Inspector General, upon notifying the Public Counsel and the director, the probation administrator, or the executive director, may distribute the report, to the extent that it is relevant to a child's welfare, to the guardian ad litem and attorneys in the juvenile court in which a case is pending involving the child or family who is the subject of the report. The report shall not be distributed beyond the parties except through the appropriate court procedures to the judge.

(3) A report that identifies misconduct, misfeasance, malfeasance, or violation of statute, rules, or regulations by an employee of the department, the juvenile services division, the commission, a private agency, a licensed child care facility, or another provider that is relevant to providing appropriate supervision of an employee may be shared with the employer of such employee. The employer may not further distribute the report or any confidential information contained in the report.

**43-4328. Report; director; accept, reject, or request modification; when final; written response; corrected report; credentialing issue; how treated.**

(1) Within fifteen days after a report is presented to the director, the probation administrator, or the executive director under section 43-4327, he or she shall determine whether to accept, reject, or request in writing modification of the recommendations contained in the report. The Inspector General, with input from the Public Counsel, may consider the director's, probation administrator's, or executive director's request for modifications but is not obligated to accept such request. Such report shall become final upon the decision of the director, the probation administrator, or the executive director to accept or reject the recommendations in the report or, if the director, the probation administrator, or the executive director requests modifications, within fifteen days after such request or after the Inspector General incorporates such modifications, whichever occurs earlier.

(2) Within fifteen days after the report is presented to the director, the probation administrator, or the executive director, the report shall be presented to the foster parent, private agency, licensed child care facility, or other provider of child welfare services or juvenile justice services that is the subject of the report and to persons involved in the implementation of the recommendations in the report. Within forty-five days after receipt of the report, the foster parent, private agency, licensed child care facility, or other provider may submit a written response to the office to correct any factual errors in the report. The Inspector General, with input from the Public Counsel, shall consider all materials submitted under this subsection to determine whether a corrected report shall be issued. If the Inspector General determines that a corrected report is necessary, the corrected report shall be issued within fifteen days after receipt of the written response.

(3) If the Inspector General does not issue a corrected report pursuant to subsection (2) of this section, or if the corrected report does not address all issues raised in the written response, the foster parent, private agency, licensed child care facility, or other provider may request that its written response, or portions of the response, be appended to the report or corrected report.

(4) A report which raises issues related to credentialing under the Uniform Credentialing Act shall be submitted to the appropriate credentialing board under the act.

**43-4329. Report or work product; no court review.**

No report or other work product of an investigation by the Inspector General shall be reviewable in any court. Neither the Inspector General nor any member of his or her staff shall be required to testify or produce evidence in any judicial or administrative proceeding concerning matters within his or her official cognizance except in a proceeding brought to enforce the Office of Inspector General of Nebraska Child Welfare Act.

**43-4330. Inspector General; investigation of complaints; priority and selection.**

The Office of Inspector General of Nebraska Child Welfare Act does not require the Inspector General to investigate all complaints. The Inspector General, with input from the Public Counsel, shall prioritize and select investigations and inquiries that further the intent of the act and assist in legislative oversight of the Nebraska child welfare system and juvenile justice system. If the Inspector General determines that he or she will not investigate a complaint, the Inspector General may recommend to the parties alternative means of resolution of the issues in the complaint.

**43-4331. Summary of reports and investigations; contents.**

On or before September 15 of each year, the Inspector General shall provide to the Health and Human Services Committee of the Legislature, the Judiciary Committee of the Legislature, the Supreme Court, and the Governor a summary of reports and investigations made under the Office of Inspector General of Nebraska Child Welfare Act for the preceding year. The summary provided to the committees shall be provided electronically. The summaries shall detail recommendations and the status of implementation of recommendations and may also include recommendations to the committees regarding issues discovered through investigation, audits, inspections, and reviews by the office that will increase accountability and legislative oversight of the Nebraska child welfare system, improve operations of the department, the juvenile services division, the commission, and the Nebraska child welfare system, or deter and identify fraud, abuse, and illegal acts. Such summary shall include summaries of alternative response cases under alternative response demonstration projects implemented in accordance with sections 28-710.01, 28-712, and 28-712.01 reviewed by the Inspector General. The summaries shall not contain any confidential or identifying information concerning the subjects of the reports and investigations.

## Endnotes

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<sup>1</sup> Neb. Rev. Stat. §43-4331

<sup>2</sup> Neb. Rev. Stat. §43-4328

<sup>3</sup> Neb. Rev. Stat. §68-1207

<sup>4</sup> The difference in the numbers received by different agencies likely corresponds to different policies on which types of incidents agencies report. DHHS sends critical incidents based on Program Memo #6-2014, adopted in July 2014. Probation sends critical incidents to the OIG based on its Juvenile Incident Reporting Policy adopted in July 2015.

<sup>5</sup> Neb. Rev. Stat. §43-4318

<sup>6</sup> Neb. Rev. Stat. §43-4318

<sup>7</sup> Neb. Rev. Stat. §28-712.01 (5).

<sup>8</sup> Neb. Rev. Stat. §43-2,108 (5).

<sup>9</sup> The policies can be found on the Nebraska Judicial Branch Website:

<https://supremecourt.nebraska.gov/17532/probation-policies>.

<sup>10</sup> Jenny, Carole and Robert M. Reece, "Cutaneous Manifestations of Child Abuse." in *Child Abuse Medical Diagnosis and Management*. 3rd edition. American Academy of Pediatrics: 2009. p 24.

<sup>11</sup> The Nebraska Child Abuse and Neglect Hotline receives calls from individuals across the state concerned for children. The concerns and allegations in the call are assessed with a screening tool to see if they meet the definition of abuse and neglect. Only those reports that meet the definition are accepted for Initial Assessment.

<sup>12</sup> Title 390 Nebraska Administrative Code (NAC) Chapter 4.

<sup>13</sup> "Child Abuse and Neglect: Annual Data, Calendar Year 2014." NE DHHS.

[http://dhhs.ne.gov/children\\_family\\_services/Documents/2014CANReport.pdf](http://dhhs.ne.gov/children_family_services/Documents/2014CANReport.pdf).

<sup>14</sup> All data provided to OIG by DHHS. DHHS reported 46,303 alleged child victims.

<sup>15</sup> Neb. Rev. Stat. §28- 711 and §28-713

<sup>16</sup> Neb. Rev. Stat. §28-728

<sup>17</sup> "Child Abuse and Neglect Fatalities 2013: Statistics and Interventions." Children's Bureau: April 2015.

<https://www.childwelfare.gov/pubPDFs/fatality.pdf>. "Child Maltreatment 2014." US DHHS, Administration for Child and Families. Children's Bureau: January 2016. <http://www.acf.hhs.gov/sites/default/files/cb/cm2014.pdf#page=65>.

<sup>18</sup> Parks, Sharon PhD, et al. "Pediatric Abusive Head Trauma: Recommended Definitions for Public Health Surveillance and Research." Centers for Disease Control and Prevention, National Center for Injury Prevention and Control: April 2012. <http://www.cdc.gov/violenceprevention/pdf/pedheadtrauma-a.pdf>.

<sup>19</sup> "Child Abuse and Neglect Fatalities 2013: Statistics and Interventions." Children's Bureau: April 2015.

<https://www.childwelfare.gov/pubPDFs/fatality.pdf>.

<sup>20</sup> The time between IA closing and injury/death ranged from 11 to 209 days in high risk cases. Four of the cases fell between 11 and 70 days between the IA closing and injury or death.

<sup>21</sup> Voices for Children in Nebraska. *Kids Count in Nebraska 2014 Report*.

<sup>22</sup> Sedlak, A. J., Mettenburg, J., Basena, M., Petta, I., McPherson, K., Greene, A., & Li, S. (2010). Fourth National Incidence Study of Child Abuse and Neglect (NIS-4): Report to Congress, executive summary. Washington, DC: DHHS, Administration for Children and Families.

<sup>23</sup> "Rural Child Welfare Practice." Children's Bureau: September 2012.

<https://www.childwelfare.gov/pubPDFs/rural.pdf>.

<sup>24</sup> Neb. Rev. Stat. § 68-1207

<sup>25</sup> "Recommended Caseload Standards." Child Welfare League of America:

<http://66.227.70.18/newsevents/news030304cwlacasesload.htm>.

<sup>26</sup> *ibid*.

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- <sup>27</sup> “Caseload Report SFY 2014/2015.” DHHS: [http://nebraskalegislature.gov/FloorDocs/104/PDF/Agencies/Health\\_and\\_Human\\_Services\\_Department\\_of/538\\_20150918-151147.pdf](http://nebraskalegislature.gov/FloorDocs/104/PDF/Agencies/Health_and_Human_Services_Department_of/538_20150918-151147.pdf).
- <sup>28</sup> “10 Practices: A Child Welfare Leader’s Desk Guide to Building a High-Performing Agency.” The Annie E. Casey Foundation: April 2015. <http://www.aecf.org/m/resourcedoc/aecf-10Practicespart1-2015.pdf>.
- <sup>29</sup> *Ibid.*
- <sup>30</sup> Two examples conducted by the Children’s Research Center are a 2013 study on California’s Risk Assessment ([http://www.nccdglobal.org/sites/default/files/publication\\_pdf/risk-assessment-validation.pdf](http://www.nccdglobal.org/sites/default/files/publication_pdf/risk-assessment-validation.pdf)) and a 2015 report on Texas’ tool ([http://www.nccdglobal.org/sites/default/files/publication\\_pdf/texas\\_cps\\_risk\\_fit\\_report.pdf](http://www.nccdglobal.org/sites/default/files/publication_pdf/texas_cps_risk_fit_report.pdf)).
- <sup>31</sup> Data generated by DHHS Lifespan Health Unit. Nebraska’s abusive head trauma mortality rate was 9.71 per 100,000 for infants compared to a national average of 7.92 per 100,000. For children under 3, Nebraska’s mortality rate was 7.03 per 100,000 compared to a national average of 5.69 per 100,000.
- <sup>32</sup> Data provided to the OIG by NE DHHS. “Age of Victims with a High or Very High Risk Level and No Ongoing Case Opened.”
- <sup>33</sup> 42 U.S. Code § 5106c
- <sup>34</sup> Children’s Justice Act Application.” NDHHS. [http://dhhs.ne.gov/children\\_family\\_services/Documents/2013-2014%20CJA%20Application.pdf](http://dhhs.ne.gov/children_family_services/Documents/2013-2014%20CJA%20Application.pdf).
- <sup>35</sup> “Sudden Unexpected Infant Death and Sudden Infant Death Syndrome: Data and Statistics.” Centers for Disease Control and Prevention: Feb. 8, 2016. <http://www.cdc.gov/sids/data.htm>.
- <sup>36</sup> *Ibid.*
- <sup>37</sup> “Sudden Unexpected Infant Death (SUID).” CDC. <http://www.cdc.gov/sids/pdf/sudden-unexpected-infant-death.pdf>. *Ibid.*
- <sup>38</sup> Third only after after pregnancy-related issues – such as premature birth and labor and deliver complications – and birth defects.
- <sup>39</sup> “Nebraska Child Death Review Report: For Child Deaths Occurring in 2010 and 2011.” Nebraska Child & Maternal Death Review Team. Nebraska DHHS: November, 2015. <http://dhhs.ne.gov/publichealth/Documents/CMDRTLegislatureReport2015.pdf>.
- <sup>40</sup> NDHHS Vital Statistics. As reported in interim and final Maternal and Child Death Review Team Reports. [http://dhhs.ne.gov/publichealth/Pages/lifespanhealth\\_cdrteam\\_reports.aspx](http://dhhs.ne.gov/publichealth/Pages/lifespanhealth_cdrteam_reports.aspx).
- <sup>41</sup> “Pierre-Robin Syndrome.” Medline Plus. National Institutes of Health: <https://www.nlm.nih.gov/medlineplus/ency/article/001607.htm>.
- <sup>42</sup> “SIDS and Other Sleep-Related Infant Deaths: Expansion of Recommendations for a Safe Infant Sleeping Environment.” American Academy of Pediatrics: 2011. <http://pediatrics.aappublications.org/content/pediatrics/early/2011/10/12/peds.2011-2284.full.pdf>.
- <sup>43</sup> “Infant Death Investigation: Guidelines for the Scene Investigator.” Centers for Disease Control. [http://www.cdc.gov/sids/pdf/508suidguidelinnessingles\\_tag508.pdf](http://www.cdc.gov/sids/pdf/508suidguidelinnessingles_tag508.pdf).
- <sup>44</sup> *Ibid.*
- <sup>45</sup> Neb. Rev. Stat. §43-2606 (3) <http://nebraskalegislature.gov/laws/statutes.php?statute=43-2606>
- <sup>46</sup> Title 391 -- Children's Services Licensing. [http://dhhs.ne.gov/Pages/reg\\_t391.aspx](http://dhhs.ne.gov/Pages/reg_t391.aspx)
- <sup>47</sup> DHHS Program Memo #16-2013. pg 37. [http://dhhs.ne.gov/children\\_family\\_services/Documents/AM16-2013.pdf](http://dhhs.ne.gov/children_family_services/Documents/AM16-2013.pdf).
- <sup>48</sup> Burstain, Jane. Center for Public Policy Priorities. “A Better Understanding of Caseworker Turnover within Child Protective Services” February 4, 2009.
- <sup>49</sup> Payne, Judge James. Public Consulting Group, Inc. “Beyond Quick Fixes: What Will It Really Take to Improve Child Welfare in America?” April 23, 2014.
- <sup>50</sup> “Autism Spectrum Disorder Fact Sheet.” National Institute of Neurological Disorders and Stroke: Feb. 1, 2016. [http://www.ninds.nih.gov/disorders/autism/detail\\_autism.htm](http://www.ninds.nih.gov/disorders/autism/detail_autism.htm).
- <sup>51</sup> Neb. Rev. Stat. §28-711(1) provides: “When any physician, any medical institution, any nurse, any school employee, any social worker, the Inspector General appointed under section 43-4317, or any other person has reasonable cause to believe that a child has been subjected to child abuse or neglect or observes such child being



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subjected to conditions or circumstances which reasonably would result in child abuse or neglect, he or she shall report such incident or cause a report of child abuse or neglect to be made to the proper law enforcement agency or to the department on the toll-free number established by subsection (2) of this section.”

<sup>52</sup> “Juvenile Responsive Case Management Standards Protocol.” Approved April 2014.

<sup>53</sup> With the exception of the Youth Rehabilitation and Treatment Centers and a handful of youth currently under the former OJS system.

<sup>54</sup> *Ibid.*

<sup>55</sup> “Juvenile Responsive Case Management Standards Protocol.” Approved April 2014.

<sup>56</sup> “Nebraska Probation System: Enhanced Family Engagement.” Administrative Office of Probation 8/5/2013.

<sup>lvii</sup> *Justice-Involved Youth with Intellectual and Developmental Disabilities: A Call to Action for the Juvenile Justice Community*. The Arc’s National Center on Criminal Justice and Disability (NCCJD), Violence, Abuse and Bullying Affecting People with Intellectual/Developmental Disabilities (Washington, D.C.: The Arc, 2015).

<sup>lviii</sup> Herz, Denise et al. *Addressing the Needs of Multi-System Youth: Strengthening the Connection between Child Welfare and Juvenile Justice*. Center for Juvenile Justice Reform and Robert F. Kennedy Children’s Action Corps: March 2012. [http://cijr.georgetown.edu/wp-content/uploads/2015/03/MultiSystemYouth\\_March2012.pdf](http://cijr.georgetown.edu/wp-content/uploads/2015/03/MultiSystemYouth_March2012.pdf).

<sup>lix</sup> “Juvenile Crossover Youth Practice Model.” <https://supremecourt.nebraska.gov/10794/juvenile-crossover-youth-practice-model>.

<sup>60</sup> Program Memo #17-2013: Ongoing Case Management.

[http://dhhs.ne.gov/children\\_family\\_services/Documents/AM17-2013.pdf](http://dhhs.ne.gov/children_family_services/Documents/AM17-2013.pdf).

<sup>61</sup> Herz, Denise et al. *Addressing the Needs of Multi-System Youth: Strengthening the Connection between Child Welfare and Juvenile Justice*. Center for Juvenile Justice Reform and Robert F. Kennedy Children’s Action Corps: March 2012. [http://cijr.georgetown.edu/wp-content/uploads/2015/03/MultiSystemYouth\\_March2012.pdf](http://cijr.georgetown.edu/wp-content/uploads/2015/03/MultiSystemYouth_March2012.pdf).

<sup>62</sup> “Juvenile Crossover Youth Practice Model.” <https://supremecourt.nebraska.gov/10794/juvenile-crossover-youthpractice-model>.

<sup>63</sup> *Justice-Involved Youth with Intellectual and Developmental Disabilities: A Call to Action for the Juvenile Justice Community*. The Arc’s National Center on Criminal Justice and Disability (NCCJD), Violence, Abuse and Bullying Affecting People with Intellectual/Developmental Disabilities (Washington, D.C.: The Arc, 2015). The 65 percent is based on a broad definition of disability, including not just youth with I/DD, but all those who are provided protections under the Individuals with Disabilities Education Act and Americans with Disabilities Act.

<sup>64</sup> Youth Rehabilitation and Treatment Center-Kearney Annual Report: SFY 2014/15.

[http://dhhs.ne.gov/children\\_family\\_services/Documents/YRTC-KAnnualReport.pdf](http://dhhs.ne.gov/children_family_services/Documents/YRTC-KAnnualReport.pdf).

<sup>65</sup> Neb. Rev. Stat. §43-286 (ii)(B)(II)

<sup>66</sup> Youth Rehabilitation and Treatment Center-Kearney Annual Report: SFY 2014/15.

[http://dhhs.ne.gov/children\\_family\\_services/Documents/YRTC-KAnnualReport.pdf](http://dhhs.ne.gov/children_family_services/Documents/YRTC-KAnnualReport.pdf). See also “Data Snapshot: Nebraska’s Youth Rehabilitation and Treatment Centers.” Voices for Children in Nebraska: July 2015.

[http://issuu.com/voicesne/docs/yrtc\\_data\\_snapshot/1?e=3780822/14016087](http://issuu.com/voicesne/docs/yrtc_data_snapshot/1?e=3780822/14016087)

<sup>67</sup> Neb. Rev. Stat. §43-246.01 and §29-1816

<sup>68</sup> Neb. Rev. Stat. §43-405.

<sup>69</sup> Neb. Rev. Stat. §43-407.

<sup>70</sup> “Phase I Strategic Recommendations.” OJS Committee: December 2013. <http://www.nijn.org/uploads/digital-library/Nebraska-Juvenile-Services-Committee-Report-12.13.pdf>.

<sup>71</sup> Plans to implement any Mendota-like programming stopped shortly after the new facility administrator began in late Spring 2016.

<sup>72</sup> Neb. Rev. Stat. § 43-285.

<sup>73</sup> Neb. Rev. Stat. § 43-279.01.

<sup>74</sup> Neb. Rev. Stat. § 43-286.

<sup>75</sup> Neb. Rev. Stat. §83-4,125 (3).

<sup>76</sup> <http://www.cdc.gov/violenceprevention/suicide/definitions.html>