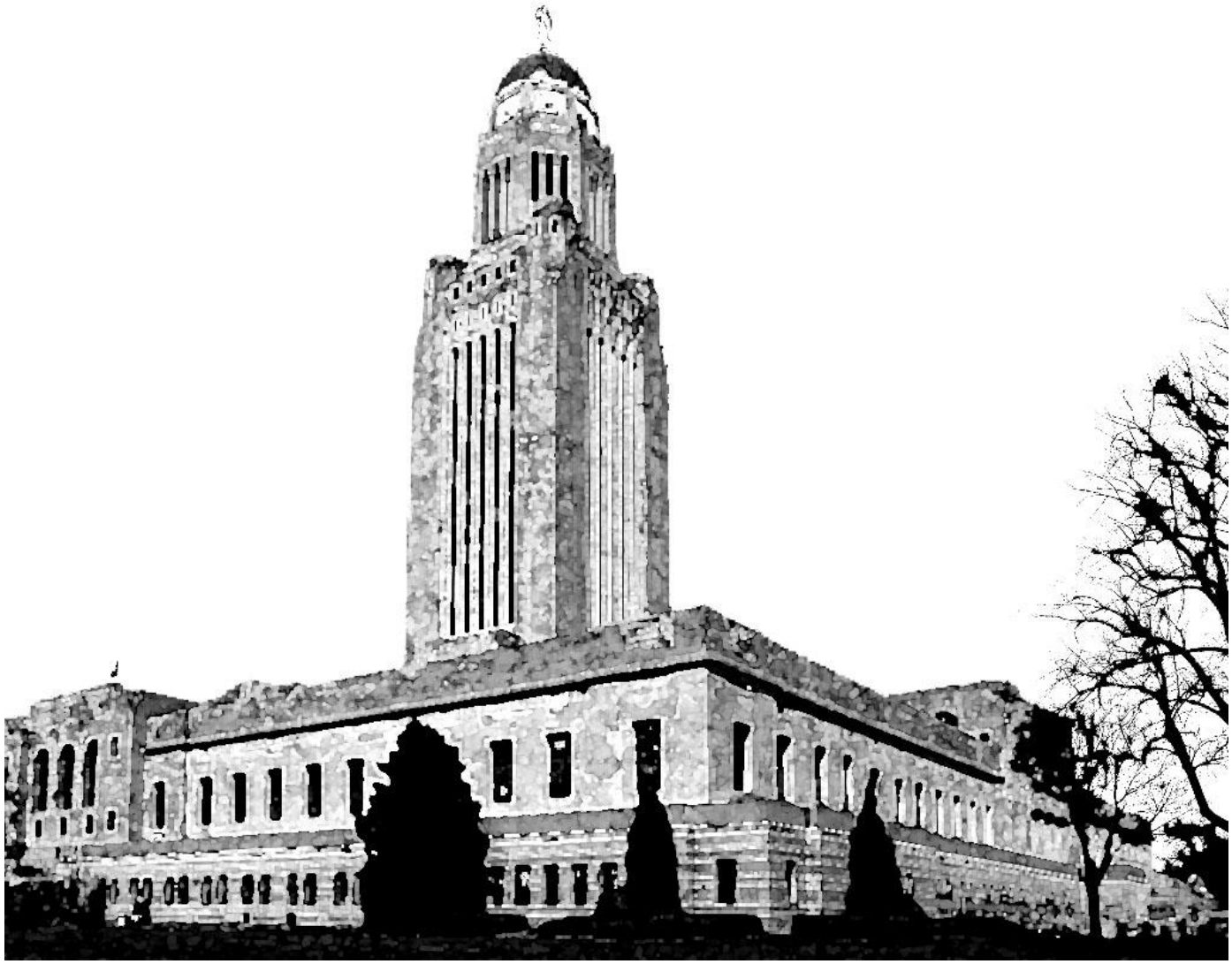
Office of
Inspector General of Nebraska Child Welfare

Annual Report

2016-2017



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

In 2012, the Office of Inspector General of Nebraska Child Welfare (OIG) was created to provide increased accountability and oversight of the child welfare and juvenile justice system and assist in improving system operations.

Five years later, the OIG has firmly established an independent, impartial program of investigation and performance review designed to foster high performance, efficiency, and integrity at the Nebraska agencies whose actions directly impact our state's most vulnerable children and families.

Nebraska has devoted time, energy, and resources to reforming the child welfare and juvenile justice system in the past five years. There have undoubtedly been significant improvements. Agencies implementing reform efforts naturally tend to highlight areas of progress.

Nebraska relies on the OIG to critically examine and shed light on areas of the child welfare and juvenile justice system that are not performing as they should. The OIG is tasked with examining child death, serious injury, misconduct, poor performance, and violations of policy, regulations, and laws. The OIG takes this obligation, along with its mandate to recommend changes and improvements, very seriously.

This year's Annual Report highlights the OIG's oversight of, and recommendations to, a variety of child welfare and juvenile justice agencies. The report notes areas where needed improvements have been made, such as the operations of the Youth Rehabilitation and Treatment Centers. The report also points out areas where more must be done to ensure that children are safe and well, and the systems serving them are performing efficiently and effectively, including ongoing issues with caseload and workload of the child welfare workforce, and how the juvenile justice system serves vulnerable youth.

It is an honor to serve as your Inspector General of Nebraska Child Welfare. I remain committed to the proper balance between our three branches of government, and genuinely appreciate your support of transparency and the search for truth in government and in the operations of our child welfare and juvenile justice systems.

Thank you for your time and attention to this report.

Very Sincerely,

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.

Housed within the Nebraska Legislature, 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 system. The OIG has no authority over the operations of agencies administering the child welfare and juvenile justice system. Instead, investigations and reviews function as part of the Legislature's oversight of these important state functions.

Each year, the OIG is required by law to publish an Annual Report. The report must provide a summary of the OIG's investigations, including the recommendations it has made to agencies and their implementation status.[1] The following Annual Report summarizes the work of the OIG from July 1, 2016 to June 30, 2017 and provides updates on OIG recommendations to child welfare and juvenile justice agencies and divisions made in prior fiscal years.

OIG Recommendations

Over the past five years, the OIG has issued 63 recommendations for improvement to the Department of Health and Human Services (DHHS), Administrative Office of Probation- Juvenile Services Division (Probation), and private agencies, as part of investigative reports. Sixteen of the 63 recommendations were made during the 2016-2017 fiscal year.

Agencies have responded differently to OIG reports and recommendations. This report highlights major changes, progress, or trends in the implementation of recommendations. A full list of recommendations and their implementation status can be found in Appendix A.

Administrative Office of Probation - Juvenile Services Division

Since 2015, the OIG has been charged with investigating complaints and allegations of wrongdoing stemming from the juvenile probation system. Additionally, the OIG was tasked with investigating every death and serious injury of a juvenile probationer.

Since that time, the OIG has issued two reports of investigation into the deaths of youth supervised by or receiving services from Probation and made 13 recommendations to Probation in those reports. The OIG's recommendations focused on: better serving youth with developmental disabilities and youth dually-involved in the child welfare system; improving internal record-keeping, quality assurance and internal oversight; adopting processes for screening youth for mental health needs and referring them to services; and, adopting policies and making improvements to how alternatives to detention are imposed and monitored. Probation accepted none of the recommendations made by the OIG in its reports of investigations.

[1] *Neb. Rev. Stat*. § 43-4331.

There is no evidence that Probation has taken steps to implement any of the OIG's recommendations or, moreover, otherwise address the issues identified in the OIG investigations into the deaths of two youth supervised by or receiving services from Probation.

DHHS - Division of Children and Family Services

The Division of Children and Family Services (CFS) is responsible for the vast majority of DHHS' child welfare operations, which has been within the OIG's jurisdiction since 2012. Since that time, the OIG has issued 11 investigative reports containing 40 recommendations related to CFS responsibilities. DHHS has accepted 38 of the recommendations.

CFS has fully completed 21 recommendations and is making progress on an additional eight. CFS has implemented all nine OIG recommendations related to the Youth Rehabilitation and Treatment Centers (YRTCs) in Kearney and Geneva, and has taken additional steps to successfully stabilize and improve the centers in the past 12 months. CFS has also completed OIG recommendations related to revising and adding to training curricula and adopting new policies that give staff guidance on a range of issues.

However, not all areas where the OIG has made recommendations have seen similar progress. Four OIG recommendations, all related to CFS caseload and workload, remain incomplete. Workforce issues remain a major problem for Nebraska's child welfare system. For an additional six recommendations, DHHS has taken some steps to comply or respond to OIG recommendations, but is not planning any further action.

DHHS - Division of Public Health

The OIG is charged with investigating deaths and serious injuries that occur in facilities that are licensed by DHHS.[2] Both child care and residential facility licensing are administered by the Division of Public Health (Public Health). The OIG has made seven recommendations to Public Health through investigative reports. Public Health is taking steps towards addressing three recommendations on preventing pediatric abusive head trauma, updating child care regulations to prevent sudden infant death, and coordinating with CFS and Probation on residential facilities.

Four of seven OIG recommendations remain incomplete. Each of the incomplete recommendations proposed changes to rules and regulations for residential facilities, which are importantly aimed at ensuring the safety and well-being of children. Public Health had taken some internal action to review and draft new regulations in 2016 prior to the OIG's investigation. However, the formal rules and regulations process has still not yet begun. It is unclear when and if recommended revisions to regulations will go forward.

DHHS - Division of Developmental Disabilities

The Division of Developmental Disabilities serves a number of youth in the child welfare and juvenile justice system. In a report on a child death, the OIG made two recommendations to DHHS related to developmental disabilities - coordination and cross-training between its own Divisions of CFS and Developmental Disabilities; and, coordination with Probation to improve the care offered to youth with

[2] *Neb. Rev. Stat*. § 43-4318.

developmental disabilities in the juvenile justice system. DHHS has fully addressed both recommendations.

Private Agencies

The OIG has issued four recommendations to private service providers through reports of investigation - two recommendations to Nebraska Families Collaborative related to training, education, and policy on infant safe sleep practices to help prevent sudden unexpected infant deaths; and, two recommendations to Owens Educational Services, Inc., which provides tracker services, related to training on suicide prevention and policy on coordinating with mental health providers who are working with youth. Both providers accepted the recommendations and have fully implemented them.

Overview of OIG Operations

In addition to conducting full investigations and issuing investigative reports, the OIG accepts and reviews hundreds of cases referred to it each year, as well as fulfilling other statutory obligations.

Cases Reported to OIG

Between July 1, 2016 and June 30, 2017, the OIG received a total of **529 intakes**. The intakes received included:

- **339** critical incidents.

  Notable trends in critical incident reporting included an increase in youth attempting suicide, a large decrease in incidents at YRTC-Kearney, and a high number of sexual abuse reports. Based on critical incident reports, the OIG opened seven new death investigations and three new serious injury investigations.

- **172** complaints.

  Complaints primarily related to DHHS operations and came from parents, grandparents, and other relatives of children involved in child welfare or juvenile justice cases. Issues raised most frequently in complaints were concerns about child abuse reports and investigations, and the placement of children.

The OIG also received 12 reports of or requests for information and 6 grievances and accompanying findings from DHHS.

OIG Capacity Challenges

By statute, the OIG must conduct investigations into death and serious injury of children and youth in the child welfare and juvenile justice systems. As of June 30, 2017, the OIG had a total of 34 death and serious injury investigations pending. Because of the resources required to thoroughly investigate each case, the OIG has had to limit the number of its investigations into other issues, incidents or concerns, including, but not limited to, conditions at residential facilities, investigations of abuse and neglect in foster homes, and performance of private providers. Whether to complete issue investigations is determined by weighing the potential benefit and impact of the investigation to improve the system against the OIG's other duties.

OIG Investigation Summaries and Updates, 2016-2017

This year, the OIG issued two investigative reports on child deaths - one on the suicide of a youth placed on alternatives to detention by Probation, and one on the death of a youth in a DHHS-licensed group home. Detailed investigation summaries and updates start on pg. 30 of this report. The OIG conducted an additional investigation into the sexual abuse of state wards, former state wards, and youth placed in residential facilities.[3]

Suicide of Youth Placed on Alternatives to Detention

A 17-year-old had been placed on alternatives to detention by Probation following a traffic accident where the youth had been illegally using prescription drugs. Twenty-five days after the alternatives to detention were imposed, the youth committed suicide at home following a fight with his girlfriend.

Probation continued to oversee the youth's compliance with the alternatives to detention and communicate with the private provider, Owens Educational Services, Inc., responsible for tracker and electronic monitoring services throughout the 25 days prior to his death.

The OIG found:

- Probation imposed alternatives to detention that differed from the type of restrictions listed in law or specified in policy and common practice.
- Indications that the youth had significant mental health problems were not addressed by Probation or the private service provider for tracker services.
- The liberty restrictions placed on the youth by Probation contributed to his social isolation and perception of being a burden, both considered factors that could increase the likelihood of suicide.
- Nebraska law and Probation policy, protocols, and processes are silent as to Probation's role in supervision and monitoring of a youth's case after an alternative to detention was decided.

Death of a State Ward in a DHHS-Licensed Group Home

A 17-year-old state ward of the Office of Juvenile Services, and resident of a group home licensed by the Public Health, was found unconscious and not breathing in a hallway. Group home staff performed CPR and called an ambulance, but the youth was pronounced dead shortly after arriving at the hospital. The autopsy found the youth's death was caused by medical issues.

In the investigation, the OIG found:

- The group home's response to the youth's health emergency was reasonable.
- The youth's overall health care was not well documented or well-coordinated while at the group home.

[3] A report of investigation was presented to DHHS during the 2017-18 fiscal year, and at the time of publication, is not final.

- Licensing requirements and regulations related to medical care are currently not sufficient to ensure that children in group homes receive appropriate medical care.
- The Division of Public Health's investigation after the youth's death was not thorough.

Sexual Abuse of State Wards, Former State Wards, & Youth in a Residential Placement

During the past year, the OIG opened an investigation into whether DHHS was taking sufficient action to prevent and respond to the sexual abuse of youth placed through the child welfare and juvenile justice systems. The investigation included a review of both the operations of the Division of Children and Family Services (CFS) and the Division of Public Health's Children's Services Licensing Program.

The OIG publically announced its investigation in December 2016. The investigation was primarily conducted between January and June 2017. The investigative report is expected to be final in Fall 2017.

Office of Inspector General Recommendations Status

The Legislature created the OIG within the legislative branch in 2012 to promote accountability, transparency, good government, and high performance in the child welfare and juvenile justice systems through a full-time program of independent investigation and performance review.

By law, the OIG investigates all deaths and serious injuries of children and youth while currently or recently involved with the child welfare or juvenile justice system or in a licensed child care facility.[4]

The OIG also investigates allegations or incidents of misconduct, misfeasance, malfeasance, statutory violations, and regulatory violations related to child welfare or juvenile justice operations 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 (Crime Commission);
- Private agencies and service providers under state contract;
- Licensed child care facilities;
- Foster parents; and
- Juvenile detention and staff secure detention centers.[5]

After carefully reviewing the evidence collected during an investigation and making findings, the OIG makes recommendations for case-specific action and systemic improvements in each report of investigation.[6] Every recommendation the OIG issues is based on the findings in a report of investigation, issues uncovered as part of the investigation, as well as research into the particular topics, and is intended to address specific errors or issues discovered during the investigation. Many of the OIG's recommendations have been issued in response to the death or serious injury of a child and were crafted to prevent similar tragedies in the future.

After receiving a report of investigation, the agency has the option of accepting, rejecting, or requesting modification of each OIG recommendation before the report is final. The Inspector General, with the Public Counsel, considers each request for modification of a recommendation, "but is not obligated to accept such request."[7] Implementation of OIG recommendations is voluntary; the OIG Act does not require agencies to accept OIG recommendations or take action in response to issues identified in OIG investigations. The OIG generally makes recommendations intended to help an agency keep children safe, fulfill statutory duties, follow internal policies and protocols, and improve efficiency and effectiveness.

In the past five years, the OIG has issued 63 recommendations through investigative reports to state agencies and private providers serving youth in the child welfare and juvenile justice system. Investigations conducted in FY2016-17, summarized later in this report, resulted in 16 of the 63

[4] *Neb. Rev. Stat*. § 43-4318.
[5] Ibid.
[6] *Neb. Rev. Stat*. § 43-4327.
[7] *Neb. Rev. Stat*. § 43-4328 (1).

recommendations. Of the sixteen new recommendations, nine were made to Probation, two to a private service provider, and five to DHHS's Division of Public Health.

By statute, the OIG is charged with providing updates each year in its Annual Report on the status of the implementation of recommendations and highlighting issues to increase accountability and legislative oversight of the child welfare and juvenile justice systems.[8]

The following sections highlight the issues discovered through the OIG's oversight of agencies and recommendations in reports of investigations, the implementation status of OIG recommendations, and other issues related to oversight and accountability that the OIG has discovered through reviews and investigations. Appendix A provides a complete list of recommendations the OIG has made to agencies and their implementation status.

Administrative Office of Probation - Juvenile Services Division

The OIG was created by the Legislature in 2012 to establish a full-time program of investigation and performance review to provide increased accountability and oversight of the Nebraska child welfare system.[9] The Legislature passed LB347 in 2015 to expand oversight and accountability of Nebraska's juvenile justice system, including the Juvenile Services Division of the Administrative Office of Probation (Probation).[10]

Since that time, the OIG has completed two investigations into the deaths of youth supervised by or receiving services from Probation. [11] As a result of these investigations, the OIG made 13 recommendations to Probation. Probation did not accept any of the recommendations and has provided no information to date to suggest that the agency has taken meaningful steps to rectify the issues identified in the OIG investigations.

Serving and Supervising Vulnerable Youth

Both OIG investigations into the deaths of youth supervised by or receiving services from Probation concerned particularly vulnerable youth. One youth was diagnosed with developmental disabilities and was also involved in the child welfare system due to concerns about his parent's ability to care for him. The other youth struggled with serious mental health problems.

The challenges in supervising vulnerable youth in the juvenile justice system are not unique to Nebraska. Across the country, juvenile justice systems serve many youth who have developmental disabilities, mental health diagnoses, or have experienced abuse and neglect. Research estimates that between 65 and 70 percent of youth who come into contact with the juvenile justice system have a mental health

[8] *Neb. Rev. Stat*. § 43-4331

[9] *Neb. Rev. Stat*. § 43-4302(1)(a)

[10] LB347 (2015) Statement of Intent

[11] One investigation is summarized on pg. 31. The other was completed in the 2015-16 fiscal year. A summary can be found in last year's OIG Annual Report.

diagnosis, with almost 30 percent requiring immediate treatment.[12] Additional studies indicate that youth who have developmental disabilities or child welfare involvement are both over-represented in the juvenile justice system and have particularly poor outcomes.[13]

In both investigations, the OIG found that Probation lacked the necessary policies and protocols for effectively meeting the needs of these youth. Based on the investigations, the OIG recommended that Probation adopt policies on serving youth with intellectual and developmental disabilities, making referrals to the child welfare system and joint case management with child welfare, and screening for mental health needs and referring to mental health services during juvenile detention intakes.

Probation rejected the report containing recommendations on serving youth with intellectual and developmental disabilities and needing or receiving child welfare services. Probation requested modification of the recommendations on screening and referring to mental health services, and after careful consideration, the OIG, with the Public Counsel, declined to modify the recommendations. Based on a review of policies and reports provided to the OIG by Probation, no action has been taken on OIG recommendations. The OIG remains concerned that Probation lacks policies and protocols to successfully serve youth with mental health needs, developmental disabilities, and child welfare involvement.

Internal Oversight & Quality Assurance

State agencies adopt policies and processes to ensure that the programs they administer abide by state law and are operated fairly, effectively, and efficiently. Internal monitoring of whether employees are following policies and whether policies are having the intended impact is important to high-quality child welfare and juvenile justice programs. Through the investigations into the deaths of youth supervised by or receiving services from Probation, the OIG found that Probation's quality assurance and oversight of its own operations was lacking.

In the investigation regarding the youth with developmental disabilities supervised by Probation who died of exposure to the elements while under the influence, the OIG found that Probation had failed to make or record home visits and a case plan for the youth. Probation had no plan of how to provide services to the youth or coordinate with other agencies to help the youth avoid law violations. Probation had no record of required supervision visits to the youth's family home or placement. The OIG also found Probation also had not followed their adopted family engagement principles meant to ensure that families participate in their child's case and help them succeed while on Probation. Probation did not respond to family concerns about the child's placement or the need for a different kind of drug testing because of the child's disability.

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[12]1 Shufelt, J.S. & Cocozza, J.C. (2006). Youth with Mental Health Disorders in the Juvenile Justice System: Results from a Multi-State, Multi-System Prevalence Study. Delmar, NY: National Center for Mental Health and Juvenile Justice.

[13] 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).
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://cjjr.georgetown.edu/wp-content/uploads/2015/03/MultiSystemYouth_March2012.pdf.

In the investigation into the death of a youth receiving services through Probation, the OIG discovered that probation officers were acting beyond their explicit authority in imposing alternatives to detention and how they were monitoring and directing private providers of these services.

The OIG recommended Probation adopt a policy on documentation and expand statewide quality assurance efforts. The OIG has also recommended that Probation adopt additional guidance and policy for officers on imposing alternatives to detention to ensure decisions are consistent and appropriate across the state.

Based on information available to the OIG, Probation has taken no action to implement these recommendations or otherwise address the issues identified in the OIG's investigations. Without consistent internal quality assurance and clear policies for staff, Probation services are likely to continue to be delivered inconsistently across the state. Errors and issues that can hinder the supervision and service of youth are unlikely to be detected before major problems arise and the youth are placed at risk.

Department of Health Human Services: Division of Children and Family Services

The OIG believes CFS has taken seriously its statutory duties to comply with OIG requests, cooperate with investigations, and respond to OIG reports of investigations since the OIG was established in 2012. CFS has turned over documentation in a timely manner and staff have promptly responded to questions and interview requests and have been candid and open with the OIG as it investigates deaths, serious injuries, and concerning situations involving vulnerable children.

As of June 30, 2017, the OIG issued 11 reports of investigations related to CFS operations. Nine reports concerned deaths and serious injuries of children and two reports examined concerns at the Youth Rehabilitation and Treatment Centers (YRTCs).

In its reports of investigations, the OIG has issued 40 recommendations involving CFS operations. DHHS has accepted 38 recommendations, rejected one, and requested modification of another, which was modified after careful consideration by the OIG with the Public Counsel. CFS has fully implemented 21 recommendations and is in the process of implementing eight additional recommendations. DHHS has taken action on six recommendations, but is not planning to fully implement. Four recommendations are incomplete.[14]

The following sections highlight significant themes and trends identified through the OIG's oversight of and recommendations for CFS operations during the past fiscal year.

Improvements at the Youth Rehabilitation and Treatment Centers

YRTC-Kearney and YRTC-Geneva are residential facilities for youth in the Nebraska juvenile justice system administered by CFS's Office of Juvenile Services (OJS). As Nebraska has implemented a number of juvenile justice reforms, concerns about the facilities' effectiveness and safety have been widely

[14] A full list of recommendations and their implementation status can be found in Appendix A.

discussed by the Legislature and in the media. In past years, escapes, attempted escapes, and other concerning events at the YRTCs have accounted for up to a third of all critical incidents sent to the OIG.

During FY2014-15, the OIG issued a report of investigation into an alleged sexual assault of a youth in a transportation van and the implementation of the Prison Rape Elimination Act (PREA) standards at YRTC-Geneva. During FY2015-16, the OIG issued a report of investigation into deteriorating conditions at YRTC-Kearney under interim management, including an increasing number of escapes, assaults, suicide attempts, and self-harming behavior.

In all, the OIG has made nine recommendations to DHHS related to YRTC operations, including: adopting standards for transporting youth to and from the YRTCs, changes and clarifications to policy, disbanding or restructuring a disciplinary confinement program, implementing quality assurance and data monitoring, planning around staffing issues at YRTC-Kearney, and providing additional DHHS Central Office support, and oversight for needed changes to facility operations.

Over the past year, DHHS has noticeably prioritized stabilization and improvement at the YRTCs. To date, DHHS has fully implemented all nine recommendations, including the recommendation it originally rejected - the appointment of a full-time OJS Administrator to oversee both facilities. CFS has taken meaningful steps towards digitalizing YRTC records by creating an online system where facility incident reports can be stored and real-time data on incidents can be reviewed.

In addition to implementing OIG recommendations, the new OJS Administrator has worked on a variety of projects to improve and standardize safety, security, and care available at the YRTCs. In the past year, the OIG has seen a significant decline in critical incidents from the YRTC-Kearney in particular, suggesting a significant improvement in conditions at the facility over the past 12 months. While challenges for both facilities remain, including an increasing number of youth committed to the YRTCs, CFS has devoted resources and needed leadership to making important changes that will better serve the youth and staff at these facilities.[15]

Continuing Child Welfare Caseload, Workload, and Workforce Challenges

Through investigations and reviews, the OIG has repeatedly uncovered evidence that high caseload and workload burdens, staff turnover, and vacancy issues for CFS staff have negatively impacted child welfare operations in Nebraska.

The OIG has repeatedly noted in Annual Reports that DHHS has never complied with the minimum caseload standards required by Nebraska law since 2012.[16] These caseload standards were adopted to improve the effectiveness of the child welfare workforce and help stabilize the child welfare system. This year, DHHS continues to be out of compliance with statutorily-mandated caseload standards. With

[15] The current OJS administrator has informed the OIG that the number of youth placed at the YRTCs has been increasing. This is consistent with Probation's "Reform Efforts" reports, which show a steady increase in youth placed at a YRTC since November 2016.
https://supremecourt.nebraska.gov/sites/default/files/files/14/april_2017_monthly_reform.pdf.

[16] *Neb. Rev. Stat*. § 68-1207.

a growing number of children in the system and budget cuts to child welfare operations, CFS will likely not be in compliance with the statutory caseload standards in the near future.[17]

The OIG's 2015-16 investigation of 11 deaths and serious injuries of children following a child abuse or neglect investigation highlighted how CFS was failing to meet statutory caseload standards and how high caseload and workload encouraged staff to cut corners and fail to comply with policy. In some cases, shortcuts contributed to tragic outcomes for children and families. An OIG investigation of a state ward's suicide illustrated how caseworker turnover paired with poor communication can lead to important information being overlooked and a failure to follow up on a child's needs.

Through these and other reports of investigation, the OIG made five recommendations to DHHS related to child welfare staff workload, caseload, and turnover.

In 2016, the OIG recommended that DHHS increase the initial assessment (child abuse and neglect investigations) workforce to comply with statutory caseload standards. DHHS has taken limited or no action on this recommendation. Although DHHS has explored repurposing some positions internally, they have not requested any additional positions. Available data indicates there continue to be serious concerns with the current workforce's ability to handle the number of child abuse and neglect investigations they are assigned. As of July 2017, 1,527 initial assessments determinations had not been made about child safety, risk of future maltreatment and the need for ongoing services, or whether the abuse or neglect occurred, in the required timeframe.[18] Furthermore, staff in the field were not meeting required timeframes to meet with children and families after a report of abuse and neglect in some cases, including those that DHHS policy has identified as serious enough to require a 24-hour response.[19]

The OIG also recommended that DHHS expand internal data available on caseloads and report publicly on compliance with caseload standards on a monthly basis. DHHS has been developing and piloting a workload tool for internal use, but the tool is not intended to be used to determine compliance with statutory caseload standards. CFS Administrators have indicated that calculating caseload standards according to statutory requirements is burdensome and they do not find the numbers useful. The only numbers made available by DHHS on statutory caseload standard compliance are from a single day each year.[20] Reporting the statistics in this way makes it difficult to determine the extent to which DHHS is falling short of compliance.

DHHS has not fully addressed two recommendations related to staffing, especially supervisory staffing, at the Child Abuse and Neglect Hotline. Starting in September 2016, DHHS reduced workload expectations for supervisors by no longer requiring them to review every call to the Hotline. The Hotline has only four supervisors and receives over 6,000 calls each month, the majority of which a supervisor must review. Given the number of calls into the Hotline and the other duties supervisors have, the OIG

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[17] DHHS Point In Time Chart shows an increase in overall state wards, and wards in out-of-home care. The chart does not account for children and families receiving non-court services. http://dhhs.ne.gov/children_family_services/Documents/PITRunChart.pdf. Retrieved September 6, 2017.

[18] DHHS CQI Report - July 2017. http://dhhs.ne.gov/children_family_services/CQI%20Monthly%20Reports/CQI%20July%202017.pdf.

[19] *Id.*

[20] DHHS caseload report. http://nebraskalegislature.gov/FloorDocs/104/PDF/Agencies/Health_and_Human_Services__Department_of/538_20160915-114256.pdf.

believes more can be done to ensure that the Hotline workforce is sufficiently able to appropriately screen calls.

Only one of the OIG's recommendations in this area - enhancing efforts to reduce caseworker turnover - has been fully implemented. Among the changes made by DHHS are adjustments to and monitoring of recruiting strategies for child welfare workers, revisions to new worker training to make it more effective and minimize the amount of time trainees must spend in Lincoln, and development of a supervisory training program. Although the OIG has determined sufficient action has been taken to implement its recommendation to enhance efforts to reduce caseworker turnover, DHHS has further efforts planned to address turnover in the coming year. Despite the enhanced efforts of DHHS to reduce turnover, it continues to be a *significant* challenge for the child welfare workforce.

In addition to caseload and workload, the OIG has made six recommendations related to training and experience of the child welfare workforce. Multiple OIG investigations have revealed an overall lack of necessary training, experience, and knowledge among staff to appropriately perform their duties. DHHS has revised training for both new and existing staff to ensure that they have additional information about mental health, psychotropic medications, developmental disabilities, and safe sleep for infants. The only recommendation in which DHHS has not made any significant progress is increasing the experience and specialization of staff assigned to initial assessment.

Expanding Prevention Efforts

Through its investigations, the OIG has found a number of trends in the types of deaths and serious injuries reported to the office. The OIG has made a number of recommendations to DHHS designed to better prepare the child welfare system to educate themselves, parents, and caregivers and prevent common causes of death and serious injury. DHHS has fully complied or is in the process of complying with these OIG recommendations.

The OIG investigated the deaths of seven infants involved with the child welfare system who died suddenly and unexpectedly in unsafe sleeping environments. The OIG recommended DHHS increase both staff training in addition to making safe sleep information for parents and caregivers more available. The OIG recommended DHHS incorporate conversations about safe sleep and checks of infant sleeping areas into home visits. CFS made changes to policy and training, and developed a packet of information given to parents and caregivers. CFS has fully implemented OIG recommendations related to preventing sudden unexpected infant death.

The OIG also made recommendations to DHHS about preventing pediatric abusive head trauma (which includes "shaken baby syndrome"). Eight of the serious injuries and deaths the OIG investigated in 2015 and 2016 involved abusive head trauma. CFS has fully implemented the OIG's recommendation to provide information for caseworkers and families on preventing pediatric abusive head trauma, and has gone beyond the recommendation by partnering with the Division of Public Health to enhance DHHS prevention efforts. In addition, CFS sponsored a "Coping with Crying" public service announcement.

Finally, the OIG has noted in its investigations that CFS works with immigrant or refugee families and families that do not speak English as a first language. In these investigations, the OIG has found a limited number of resources and information available to these families to help prevent child abuse and neglect. In 2015, the OIG recommended that DHHS assess both what specific services are available to these families and what special needs these families might have when it comes to child abuse

prevention. CFS is currently participating in a statewide assessment conducted by Bring Up Nebraska, a public-private child abuse prevention initiative.

Department of Health Human Services: Division of Public Health

The Division of Public Health (Public Health) administers a number of programs that impact the child welfare and juvenile justice systems the OIG is responsible for reviewing. The OIG is charged with investigating deaths and serious injuries that occur in facilities that are licensed by DHHS.[21] Both child care and residential facility licensing are administered by Public Health. The OIG has made seven recommendations to Public Health through investigative reports. Public Health has taken action to comply with three of the OIG's recommendations. Four recommendations remain incomplete.

Residential Facility Licensing

In 2017, the OIG conducted an investigation into the death of a state ward due to a medical condition while placed in a group home licensed by Public Health (see summary on pg 42). The OIG made five recommendations to Public Health related to licensing operations and requirements for residential child-caring agencies. The OIG made four recommendations related to regulations governing residential facilities and one related to Public Health's coordination with CFS and Probation.

The OIG recommended that Public Health adopt new rules and regulations for licensing residential facilities as soon as possible, and ensure they include clear or expanded standards on medication management, medical record keeping, obtaining consent for medical treatment, and coordinating medical care. Nebraska's regulations for group homes and other residential facilities which care for youth have not been updated in over a decade. Although a new law giving Public Health expanded duties and authority in its licensing of residential facilities went into effect in 2013, corresponding regulations have not been adopted. Regulations governing residential facilities that care for some of Nebraska's most high-needs and high-risk youth are minimal, out of date, and do not ensure facilities are safe and suitable for the children in their care.

Public Health has internally drafted potential new regulations for residential facility licensing. These have been in draft form for over two years and have not yet been sent to the Secretary of State, the first step in officially promulgating new regulations.

Child Care Licensing

In 2016, the OIG investigated four deaths that occurred in licensed child care facilities. Each death involved an infant dying suddenly and unexpectedly in an unsafe sleep environment. Each facility involved was a family child care home, rather than a child care center.

The OIG recommended that Public Health revise child care licensing regulations to ensure that all caregivers are trained on infant safe sleep before a child care license is issued. The OIG determined the current Nebraska regulations, which give providers three years before getting trained on infant safe sleep, were inadequate. Some of the child care providers in the deaths the OIG investigated had never

[21] *Neb. Rev. Stat.* § 43-4318.

been trained on safe sleep. DHHS accepted the recommendation, and in 2016 put in a request that the requirement for training on safe sleep be addressed through legislation. No legislation was introduced in 2017, and DHHS is currently revising child care regulations, including adding requirements related to safe sleep, with the aim of completing a draft regulation by the end December 2017.

Prevention Initiatives

Public Health also runs a number of programs that gather data and coordinate prevention initiatives, including initiatives on shaken baby syndrome/pediatric abusive head trauma. The OIG issued a recommendation that Public Health increase its data collection related to pediatric abusive head trauma and revise the shaken baby syndrome materials it is required to distribute by Nebraska law.[22] The OIG learned that the Child Safety Collaborative Innovation & Improvement Network (CoIIN), housed at Public Health, has developed a Crying Plan and is gathering data from Hospitals on the materials they distribute and education they provide on shaken baby syndrome.

Department of Health Human Services: Division of Developmental Disabilities

Nebraska's child welfare and juvenile justice system serves many youth with diagnosed developmental disabilities, some of whom receive services from the DHHS Division of Developmental Disabilities (DD). In 2016, the OIG investigated the death of a youth served by Probation, CFS, and DD. The OIG made two recommendations to DHHS related to developmental disabilities: coordination and cross-training between its own Divisions of CFS and DD and coordination with Probation to improve the care offered to youth with developmental disabilities in the juvenile justice system.

Both recommendations have been fully implemented. DD has developed and reviewed training materials for CFS, and continues to participate in the Cross Divisions Solution Team with CFS. DD developed and disseminated a handout for probation officers and court stakeholders providing details on the Home and Community Based Waivers available to people with disabilities, presented a training at the Nebraska Juvenile Justice Association Conference, attends weekly system collaboration meetings with Probation, and has used clinical staff to assess youth committed to YRTCs for DD service eligibility.

Private Service Providers

Oversight of private providers who contract with the state for child welfare and juvenile justice services has been within the OIG's jurisdiction since its creation in 2012. Most children and families involved in the child welfare and juvenile justice system have contact with private service providers - from entities operating residential facilities and supporting foster homes, to those providing in-home services and family support, to the privatized child welfare case management provided by Nebraska Families Collaborative (NFC) in Douglas and Sarpy counties.

While investigations of death and serious injuries often include review of private agency records, the OIG has spent more resources to date examining and making recommendations related to DHHS and Probation oversight and coordination with private service providers, rather than making

[22] *Neb. Rev. Stat.* §§ 71-2103 and 2104.

recommendations to private service providers themselves. In general, private providers have been receptive to OIG oversight, providing documentation and making staff freely available for interviews.

To date, the OIG has issued four recommendations to private service providers through reports of investigations - two recommendations to NFC related to training, education, and policy on infant safe sleep practices to help prevent sudden unexpected infant deaths and two recommendations to Owens Educational Services, Inc., which provides tracker services, related to training on suicide prevention and policy on coordinating with mental health providers who are working with youth. Both providers accepted and fully implemented the recommendations.

Operations of the Office of Inspector General, 2016-2017

The following section of the Annual Report provides information on the operations of the OIG during FY2016-17. This includes cases reviewed by the OIG in the past year, pending death and serious injury investigations, and recent changes to statutes impacting the office.

Cases Reviewed by the Office of Inspector General

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, 2016 and June 30, 2017, the OIG received a total of **529 intakes**. The intakes received included:

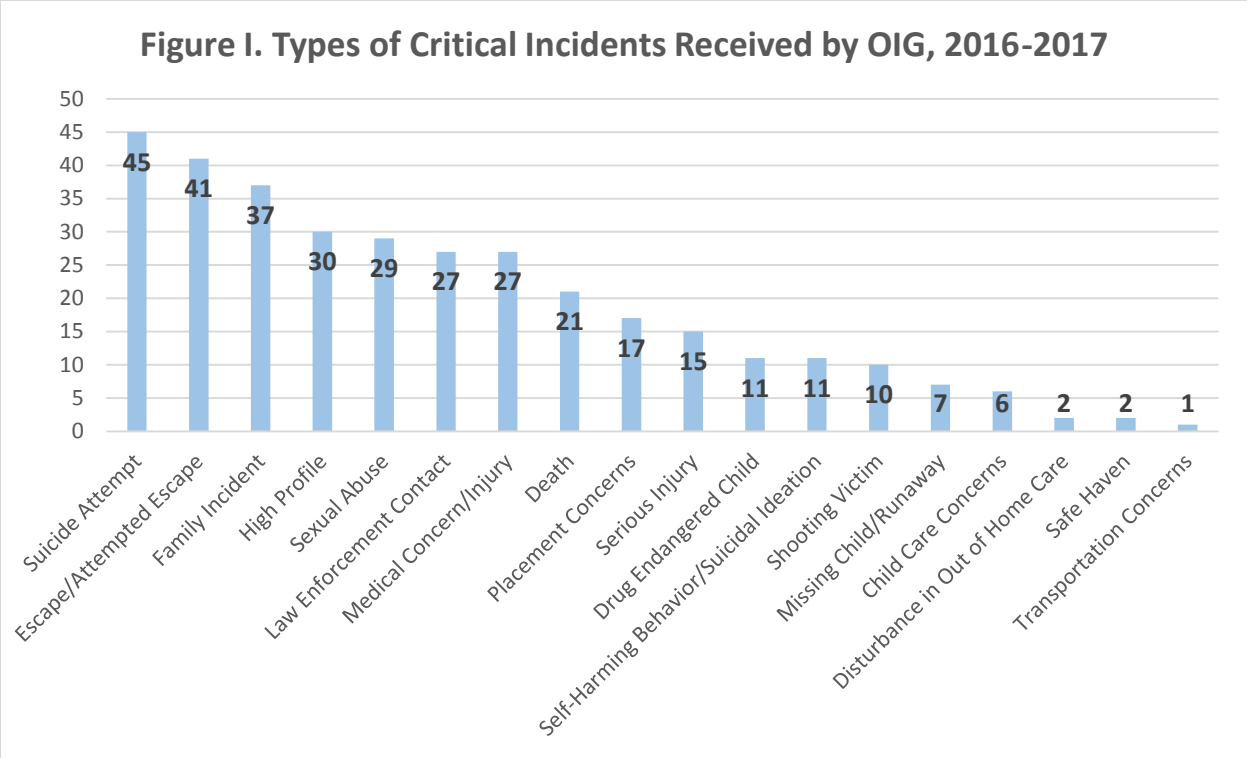
- **339** critical incidents;
- **172** complaints;
- **12** reports of or requests for information; and,
- **6** grievances and accompanying findings from DHHS.

The OIG conducts a preliminary investigation, including a document review, on every complaint, critical incident, and grievance finding. Based on the preliminary investigation, the OIG determines whether a full investigation is justified or required and what additional actions may be appropriate.

Critical Incidents Received by the OIG

Critical incident reports bring a range of issues to the OIG's attention. Figure I. shows the type of concerns included in the 339 reports involving 309 youth that were reported to the OIG in the past year. Thirty youth were involved in more than one incident.

Of the critical incidents, 251 were reported by DHHS, 87 by Probation, and one by a local detention center. At the time of the critical incident, 76 percent of the youth were actively involved in Nebraska's child welfare or juvenile justice system (see Table I) and 62 percent were placed in out-of-home care (see Table II).



Among the notable trends in critical incidents this year were:

- **Rising number of attempted suicides**

The OIG received 45 reports of suicide attempts by 38 children, ranging from age seven to eighteen. Five children attempted suicide twice in the twelve month period and one child attempted suicide three times. Twenty-three children were state wards, six were supervised by Probation, six were served by both Probation and DHHS, and three had no system involvement at the time of their suicide attempt.

- **Decline in critical incidents at the Youth Rehabilitation and Treatment Center - Kearney**

The OIG received 92 fewer critical incidents from DHHS this fiscal year, largely as a result of a significant decline in reports from the YRTC-Kearney. During FY2015-16, 132 critical incidents were reported while a youth was placed at a YRTC. This year, only 44 critical incidents at a YRTC were reported - 22 at YRTC-Geneva and 22 at YRTC-Kearney.

  - *Escapes and attempted escapes*

The OIG received twelve reports of escapes or attempted escapes from the YRTC-Kearney and four reports of escapes of youth on furlough from the facility this year. This was a 76 percent decline from the 62 escapes that were reported at YRTC-Kearney during FY2015-16. During the past fiscal year, YRTC-Kearney reported fewer escapes than YRTC-Geneva.

  - *Disturbance in out of home care*

Last year, the OIG received 28 critical incident reports related to assaults, destruction of property, or other similar disturbances in an out-of-home placement. Most of these reports occurred at YRTC-Kearney. This year, the OIG only received one critical incident report related to a serious assault at YRTC-Kearney.

- **Increased reports of sexual abuse**

The OIG received 29 reports of sexual abuse of or by system-involved children, an 81 percent increase from the year prior. Twenty-four reports related to children being alleged victims of sexual abuse by a community member, foster parent, therapist, relative, and other youth. Five reports related to a system-involved youth allegedly sexually abusing or assaulting another person. Fourteen reports related to youth on probation, seven were state wards, five youth were served by both Probation and DHHS, and three youth had been the subject of prior child abuse or neglect investigation.

Six of these reports were incorporated into the OIG's full investigation into sexual abuse of state wards, former state wards, and youth placed in residential facilities, which took place during FY2016-17.

Table I. System Involvement at Incident

System Involvement	Critical Incidents
State Ward (3a, OJS, or 3c)	98
Probation Youth	76
Probation Youth Committed to YRTC	40
Dually Adjudicated (Probation and DHHS)	35
Prior Initial Assessment	34
None	26
Closed Case (Court, Non-Court, and Alternative Response)	10
Prior Child Abuse or Neglect Report	8
Non-Court Case	4
Ward from Another State	3
Initial Assessment	3
Alternative Response	2

Table II. Placement at Incident

Placement	Critical Incidents
Family Home	127
Foster Home	77
Residential Facility	56
YRTC, Detention	50
Missing from Care	11
Hospital	9
Developmental Disabilities Placement	3
Independent Living	3
Informal Relative Care	2
Homeless	1

Deaths and Serious Injuries Reported to the OIG

The OIG is required to investigate 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. The OIG is not required to investigate deaths that occurred by chance. Serious injury is defined as, "injury or illness caused by suspected abuse, neglect, or maltreatment which leaves a child in critical or serious condition."[23] The OIG opens death and serious injury investigations based on critical incident reporting.

Of 21 reported child deaths in 2016-2017, 11 had insufficient contact or involvement in the child welfare or juvenile justice system to merit an investigation. An additional three deaths were determined to have occurred by chance (e.g. - car accidents). The OIG opened seven investigations (see Table III).

Table III. Cause of Child Death in New OIG Investigations, FY 16-17

	State Ward	Probation Supervision	Licensed Child Care Facility
Homicide - Firearm	0	1	0
Medical	1	0	0
Sudden Unexpected Infant Death (SUID)	1	0	1
Suicide	0	1	0
Neglect	1	0	0
Unknown	1	0	0
Total	**4**	**2**	**1**

Of the 15 serious injuries reported to the OIG this year, three met the requirements to open an investigation (see Table IV). Eleven of the fifteen serious injuries reported did not have enough child welfare or juvenile justice system involvement to merit an investigation. One serious injury, on review, could not definitively be linked to abuse or neglect.

[23] *Neb. Rev. Stat.* § 43-4318.

Table IV. System Involvement in New OIG Serious Injury Investigations, FY 16-17

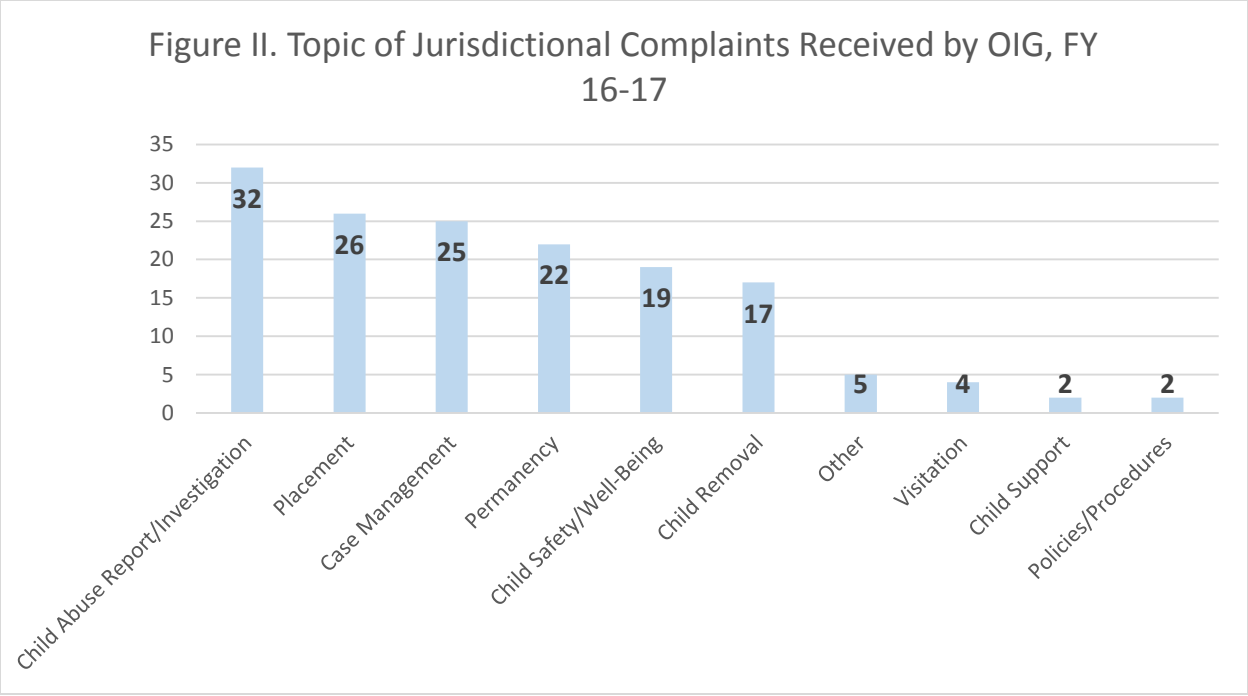
State Ward	Probation Supervision	Former Ward	Initial Assessment in Past 12 months	Licensed Child Care Facility
0	0	1	2	0

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 or Juvenile Services Division (Probation);
3. The Nebraska Commission on Law Enforcement and Criminal Justice's (Crime Commission) 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.[24]

In the past year, the OIG received **172 complaints**, 154 of which it had the jurisdiction to further investigate. Table V. shows the number of complaints received related to different agencies.



[24] *Neb. Rev. Stat*. § 43-4318.

The OIG received **complaints from citizens in 30 of Nebraska's 93 counties**, in addition to nine complaints received from those residing in other states. As illustrated in Table VI, complaints were most often made by parents, grandparents, and other relatives concerned about the children or cases they brought to the OIG's attention. The OIG also received a higher number of complaints from child welfare or juvenile justice system professionals than in the past.

As shown in Figure II., the OIG received complaints on a range of issues. The topic of complaints most frequently received related to concerns about whether child abuse reports were being appropriately screened and investigated. Concerns about whether children were placed in safe and appropriate settings, as well as concerns about how cases were being managed by DHHS, NFC, or Probation, were also frequently reported to the OIG.

Table V. Subjects of Complaints, FY 15-16

AGENCY	#
DHHS	110
Private Provider - Nebraska Families Collaborative	33
Court (no jurisdiction)	14
Probation	5
Other Agencies (no jurisdiction)	4
Other Private Provider	4

Table VI. Complainant's Relationship to Case or Child

COMPLAINANT	#
Parent or Guardian	88
Grandparent or Other Relative	28
System Professional	20
Member of Public	16
Foster Parent	6
Health Care Professional	5
Child Care Provider or Educator	4
Government Officials and Staff	2
Internal	1
Anonymous	1

Alternative Response Cases Reviewed by the OIG

The OIG is specifically tasked with reviewing and investigating complaints related to Alternative Response, a pilot project that began in 2014.[25] Alternative Response was implemented by DHHS to change the way the system responds to some child abuse and neglect reports.

[25] *Neb. Rev. Stat*. § 28-712.01(5).

By statute, the OIG must report on any alternative response (AR) cases it reviews in its Annual Report.[26] In the past, the OIG has not received complaints or critical incidents related to Alternative Response. This year, the OIG received three complaints related to open or closed AR cases and critical incidents about three youth who were served through AR. The OIG conducted a preliminary review on each of the cases, but none resulted in full investigations.

The following complaints and critical incidents were reported to the OIG concerning Alternative Response cases:

1. The father of two children involved in an open AR case was arrested for domestic violence, child neglect, and animal abuse. The AR case originally opened due to allegations of domestic violence and physical abuse. After the initial report, the parents separated and shared custody. The father received a substance abuse evaluation and a family support worker had been assigned prior to his arrest. The children were determined to be safe with their mother and did not enter the child welfare system.

2. A child's mother involved in a prior AR case was arrested after assaulting her own mother while intoxicated. The child was placed by law enforcement in her father's custody. The closed AR case had alleged alcohol use and improper supervision by the mother. The family had declined services.

3. The OIG received a complaint that an ineligible report related to a co-sleeping child death and mother with an extensive child welfare and drug use history, was accepted for AR. The OIG reviewed the report and determined that it was not an AR case; it received a traditional response. Furthermore, the actual report referenced was not an allegation against the mother, but a neglect allegation against the guardian of one of her children.

4. The OIG received a complaint that an ineligible report related to inability to care for a medically fragile infant was accepted for AR. The OIG determined that no exclusionary criteria were present. The mother accepted AR services as well as home health care, home visiting, Early Development Network services, and housing services.

5. The OIG received a complaint that an ineligible report related to physical abuse of a four-year-old that left a bruise was accepted for AR. As part of the AR, DHHS determined the child was safe and the family did not accept services. The OIG determined that the report was correctly screened at the Child Abuse and Neglect Hotline. Bruising does not exclude a report from being screened for AR.

Juvenile Room Confinement

In 2016, the Legislature passed LB894 to, among other things, provide increased accountability and oversight regarding the use of room confinement for juveniles. The bill defined room confinement as "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."[27] Under the new law, juvenile facilities are required to

[26] *Neb. Rev. Stat.* § 43-4331.
[27] *Neb. Rev. Stat.* § 83-4,125(4).

document the use of room confinement and submit a quarterly report to the Legislature.[28] Juvenile facility is defined to include "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."[29] A residential child-caring agency means any person or entity "that provides care for four or more children and that is not a foster family home as defined in section 71-1901."[30]

LB894 became operative on July 21, 2016. Pursuant to statute, the initial quarterly report was due on or before October 14, 2016. The OIG identified 45 juvenile facilities subject to the law and provided the facilities with data collection definitions and guidance on reporting requirements. One facility closed before the initial quarterly report was due and five facilities closed during the reporting year. Under § 83-4,134.01(2)(c), a juvenile facility "shall submit a report quarterly to the Legislature." The OIG specifically instructed juvenile facilities to submit a report each quarter, even if the number of juveniles placed in room confinement was zero.

The law requires the OIG to review all the collected data to assess the use of room confinement of juveniles and prepare an annual report of the office's findings.[31] The report is required to identify changes in policy or practice that would result in decreased use of room confinement and model evidence-based criteria to determine when room confinement of juveniles should be used.

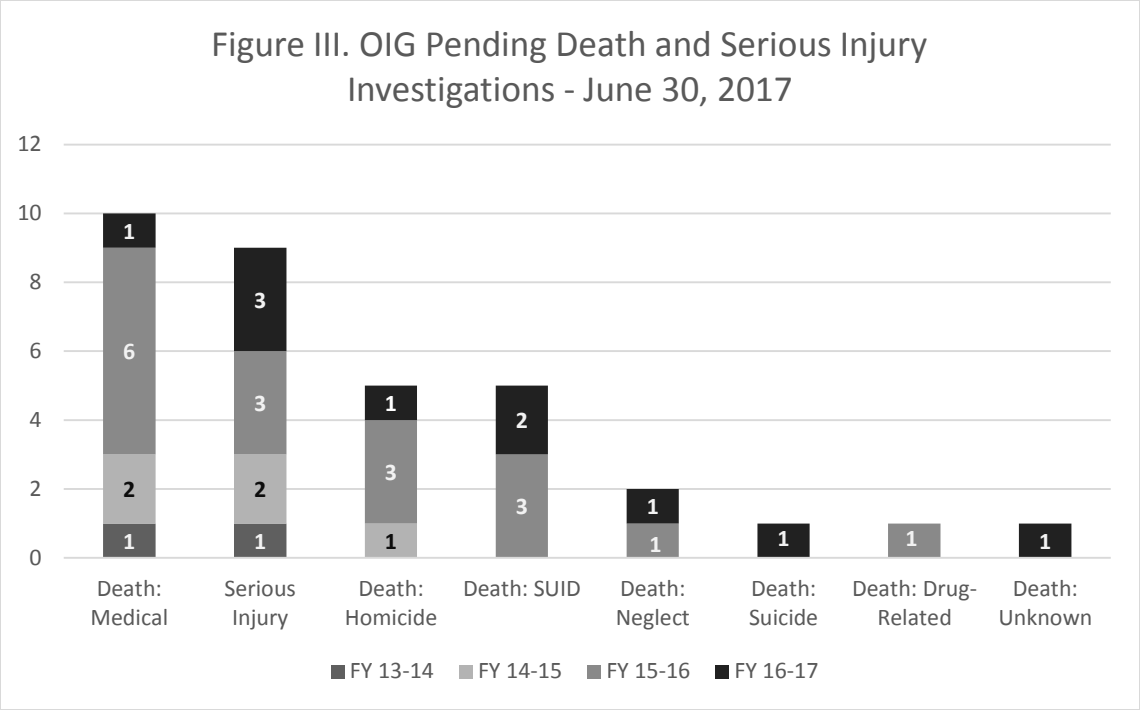
The OIG plans to release its first report on juvenile room confinement in 2017.

OIG Capacity Challenges & System Issues

The OIG can best provide accountability and oversight of Nebraska's child welfare and juvenile justice systems when it has the resources to complete investigations and reviews in both a thorough and timely manner. Investigations and reviews must be rigorous and accurate to effectively and impartially hold agencies accountable. The ability to quickly launch and conclude investigations is likewise essential to addressing concerns as they arise and providing agencies with relevant recommendations that can help them make needed, expedient adjustments. Standards for inspector general offices require very meticulous, patient, and thorough work.

Since its creation in 2012, it has grown increasingly difficult for the OIG to complete statutorily-required investigations in a timely manner. The OIG has completed and issued reports on 31 death or serious injury investigations. As of June 30, 2017, the OIG had a total of 34 pending death and serious injury investigations. These investigations are required by statute but not yet complete. Figure III. gives greater detail on the types of pending investigations and the year in which they were reported to the OIG.

[28] *Neb. Rev. Stat.* § 83-4,134.01(2).
[29] *Neb. Rev. Stat.* § 83-4,125(3).
[30] *Neb. Rev. Stat.* § 71-1926(7).
[31] *Neb. Rev. Stat.* § 83-4,134.01(2)(d).



In addition to death and serious injury of system-involved children, the OIG is charged with investigating misconduct, misfeasance, malfeasance, and violations of law and rules and regulations. The OIG does conduct preliminary investigations of all incidents and complaints reported to it. However, due to capacity constraints, the OIG has been able to open very few full investigations not related to death and serious injury of children, even when there is evidence that improper performance of duties or violations may be occurring. To date, the OIG has completed and issued two reports on violations and concerns at YRTC-Geneva and YRTC-Kearney. The OIG has also completed an investigation into sexual abuse of state wards, former state wards, and youth placed in residential facilities, which has been sent to DHHS but is not final at the time of this report's release.

One of the primary obstacles to timely and thorough investigations has been a lack of staff capacity. Until July 2014, the OIG had only one staff person - the Inspector General herself - who was responsible for taking complaints and receiving critical incidents, completing preliminary investigations on all cases, identifying cases for full investigations, conducting full investigations, writing reports, and meeting other statutory requirements of the OIG (e.g. - serving on committees). During this time, a backlog of death and serious injury investigations began to accumulate.

An intake executive assistant and assistant inspector general position were added to the OIG in July 2014. An additional assistant inspector general position was added to the office in October 2015, after the OIG's juvenile justice oversight responsibilities were significantly expanded. Other duties have been assigned to the OIG as well--alternative response oversight (2014) and juvenile room confinement use data collection, analysis, and reporting (2016).

The OIG has also been working to increase efficiencies internally - improving intake and investigative processes. The Legislature has also given the OIG additional flexibility by not requiring it to investigate deaths that occur by chance (see below). However, given the number of cases referred to the OIG each year, the backlog of investigations, and other duties assigned to the OIG, capacity challenges continue to

hinder the ability of the OIG to provide timely and thorough oversight to the child welfare and juvenile justice system.

Over the course of the past year, the OIG has encountered a number of issues which likely merit a full investigation. Due to capacity constraints, however, the OIG did not open investigations in the following areas:

- **Conditions at Residential Facilities:** Through critical incidents, complaints, and evidence discovered through investigations and reviews, the OIG is aware of persistent issues at a number of privately-run residential facilities in Nebraska, which primarily serve youth in the juvenile justice system. Concerns include abuse and neglect of residents, improper care and supervision, and inability to meet the needs of the youth placed in facilities. Although investigations have been conducted by DHHS into individual incidents, problems seem to persist.
- **Investigations into Abuse and Neglect Allegations in Foster Homes:** Through complaints and critical incident reviews, the OIG has come across a number of allegations of abuse and neglect in foster homes that have not been appropriately investigated, which has left children in dangerous, improper placements.
- **In-Program Recidivism of Youth Supervised by Juvenile Probation:** Through reviews of critical incidents, complaints, and media reports, the OIG is aware of a number of youth who were actively supervised by juvenile probation committing new offenses, including sexual assault, homicide, and other serious crimes. Currently, no information is available on rates of recidivism, or re-offending, for youth supervised by Probation. The Supreme Court does not include in-program recidivism in its uniform definition of recidivism.
- **Performance of Private Providers:** Many of the services provided to children and families in the child welfare system are provided by private corporations or non-profits. The OIG has received a number of complaints that private providers are not performing appropriately, abiding by contracts with the state, or that their internal operations are problematic.
- **Youth in the Juvenile Justice System without Parents or Guardians:** The OIG has learned of a number of cases where the parents or guardians of youth placed in out-of-home care through the juvenile justice system have abandoned them. Since Probation does not have custody of the youth it supervises, this raises concerns about who is making important decisions, including medical and educational decisions, on behalf of youth. It also impacts how, where, and when youth can exit the juvenile justice system.
- **Meeting the Mental Health Needs of System-Involved Children:** Many youth in the child welfare and juvenile justice system have significant mental health needs. Through critical incidents and complaints, the OIG is aware of numerous cases where services do not seem to be meeting the mental health needs of system-involved children. This includes youth attempting suicide and youth with mental health needs lingering in detention and other inappropriate placements, among other issues.
- **Child Welfare Caseload and Workload:** The OIG has repeatedly pointed out that DHHS is not complying with caseload standards as required in state law. Further examination of the barriers

to compliance, the degree to which DHHS is out of compliance, and administrative decision making on caseload and workload are warranted.

- **Inadequate Oversight of Spending through Probation's Voucher System:** The OIG is aware of complaints that there is not adequate oversight of payments made to private providers through Probation's voucher system. For example, there are concerns that Probation is paying providers for sessions youth do not attend or services that they do not use.
- **Youth Reaching Age of Majority While Serving a Term of Probation & Placed Out of Home:** The OIG has repeatedly been made aware of youth on Probation, ordered to an out of home placement, that age out, or turn 19, with no plan for independence. If there are no plans for when the youth turns 19, they are left vulnerable to situations such as homelessness.

If concerns in these areas persist in the coming year, the OIG will consider opening full investigations as appropriate, by weighing the potential benefit and impact of the investigation to improve the system against the OIG's other duties.

Changes to Statute Impacting the OIG

In 2017, two bills were introduced in the Nebraska Legislature to amend the Office of Inspector General for Nebraska Child Welfare Act ("the Act"). Senator Krist introduced LB6 to amend *Neb. Rev. Stat.* § 43-4325 to authorize the public release of a summarized final report of investigation upon the determination of the Inspector General and the Chairperson of the Health and Human Services Committee or the Chairperson of the Judiciary Committee that the release would be in the public's best interest. The Executive Board advanced LB6 to General File.

Senator Krist introduced LB207 to clarify and amend several sections of the Act. The bill amended § 43-4318(b) to provide that an investigation was required into a death or serious injury that occurred in a foster home, private agency, or facility only when the OIG determined that the death or serious injury did not occur by chance. The bill also amended § 43-4323 to clarify that the OIG is not responsible for the legal fees of a person resulting from a subpoena issued under the Act. LB207 amended § 43-4327(2) to clarify the distribution of a report within an agency and amended § 43-4328 to clarify an agency's process for responding to a report of investigation. The bill also added a new section to the Act to provide employment protection for a person that provides information to the OIG. This new section is codified as § 43-4332.

The Executive Board advanced LB207 to General File and designated it as a committee priority. The provisions of LB6 were incorporated into LB207 through AM507. The Legislature passed LB207 and the Governor approved the bill on April 27, 2017.

OIG's Oversight Role within the Nebraska Legislature

In 2015, as mentioned earlier in this report, the Legislature passed LB347 and expanded the OIG's jurisdiction to include not only child welfare, but all of the juvenile justice system as well. The bill specifically included Juvenile Probation in the OIG's program of investigation and performance review.

Shortly after LB347 became effective, the OIG expressed "significant concerns about the transparency of the Administrative Office of Probation" in its 2015 Annual Report.[32] After a lengthy public debate about constitutional separation of powers, the Legislature passed in LB954 to clarify the balance between judicial and legislative functions in the administration and oversight of Nebraska's juvenile justice system.

Unfortunately, confusion about the OIG's role remains.

A Legislature "cannot legislate wisely or effectively in the absence of information respecting the conditions which the legislation is intended to affect or change."[33] The United States Supreme Court has held that "the power of inquiry – with process to enforce it – is an essential and appropriate auxiliary to the legislative function."[34] Legislative power is "the supreme authority except as limited by the constitution of the State, and the sovereignty of the people is exercised through their representatives in the legislature unless by the fundamental law power is elsewhere reposed."[35] The Nebraska Legislature has plenary legislative authority, except as specifically limited by the state or federal Constitutions.[36] The Legislature created the OIG within the legislative branch as one way to carry out the Legislature's authority to conduct investigations, performance reviews, and inquiries of the child welfare and juvenile justice systems in Nebraska to provide increased accountability and oversight.[37] The Legislature's power to gather information on the operation and conditions of government programs has never been considered an infringement or usurpation of the constitutionally-derived powers of the other branches of government.

As part of the roll-out of The Juvenile Justice Home-Based Initiative[38] in Nebraska, the judicial branch's Court Improvement Project (CIP) retained TerraLuna Collaborative to evaluate the Initiative and the larger picture of juvenile justice reform. According to the March 2017 evaluation, "several stakeholders in the judicial branch expressed concern over the current structure of oversight."[39] One interviewee told TerraLuna:

> The legislature also thought there was going to be oversight. Well, there's a separation of powers, now that we're in a different branch of government. One branch can't have oversight over another branch of government. So it became a problem, because then the inspector

[32] Office of Inspector General of Nebraska Child Welfare Annual Report 2014-2015
[33] *McGrain v. Daugherty*, 273 U.S. 135, 175 (1927).
[34] *Id*. at 174.
[35] *McPherson v. Blacker*, 146 U.S. 1, 25 (1892).
[36] *State ex re. Stenberg v. Moore*, 544 N.W.2d 344, 349 (Neb. 1996).
[37] *Neb. Rev. Stat.* § 43-4302(1).
[38] The Juvenile Justice Home-Based Initiative – funded by the Sherwood Foundation and the William and Ruth Scott Family Foundation – provides funding to implement Multi-Systemic Therapy (MST) and/or the Boys Town Ecological In-Home Family Treatment programs by selecting and supporting agencies that will provide these in-home services.
[39] Retrospective Developmental Evaluation of Juvenile Justice Reform in Nebraska, Part 1, Prepared for the Nebraska Court Improvement Project by TerraLuna Collaborative, March 2017.

> general is in the executive branch. They expect her to have oversight. So it became a political nightmare last year.[40]

Identifying information was removed by TerraLuna to protect interviewees' anonymity. It should be noted for clarity that the OIG is located in the legislative branch and has been since its creation in 2012.

While it was hoped that LB954 would put the issue to rest, it appears not everyone has accepted the Legislature's constitutional oversight responsibilities of juvenile justice operations administered by the judicial branch. Nevertheless, the OIG remains hopeful that the situation will eventually evolve into a more positive and productive direction.

[40] Id. at 26.

Investigation Summaries and Updates, 2016-2017

Overview of Investigations

During the 2016-17 fiscal year, the Office of Inspector General of Nebraska Child Welfare (OIG) issued two investigative reports - one to the Administrative Office of Probation (Probation) and one to the Department of Health and Human Services (DHHS). Both investigations involved child deaths. This section of the Annual Report contains detailed summaries of each investigative report, including:

1. Summaries of individual deaths and serious injuries;
2. Investigative findings;
3. Detailed recommendations the OIG made to agencies in each report;
4. Agency responses and updates to each recommendation; and,
5. Information the OIG has gathered on the implementation status of each recommendation.

In total, the OIG made 16 recommendations - nine to Probation, two to a private agency, and five to DHHS. Information on all of the recommendations made to agencies as well as their implementation status can also be found in Appendix A.

During the 2016-17 fiscal year, the OIG also conducted an investigation into sexual abuse of state wards, former state wards, and youth placed in residential facilities. However, the investigative report has not yet been finalized. A summary of the OIG's investigative process is included.

OIG Investigative Report Process

The Office of Inspector General of Nebraska Child Welfare Act (Appendix B) 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 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:
Suicide of Youth Placed on Alternatives to Detention

A 17-year-old youth had been placed on alternatives to detention by the Administrative Office of Probation (Probation) following a traffic accident where the youth had been illegally using prescription drugs. The alternatives to detention imposed by Probation included electronic monitoring and tracker services, which were provided by a private service provider, Owens Educational Services, Inc., as well as "zero curfew" (house arrest), restrictions on contact with friends, and a ban on driving.

Twenty-five days after the alternatives to detention were imposed, the youth committed suicide at home following a fight with his girlfriend. The youth had not yet been to court, so none of the restrictions placed on him were reviewed. However, Probation continued to oversee the youth's compliance with the alternatives to detention and communicate with the private provider throughout the 25 days.

The report examined the juvenile justice system's role in the events leading up to the youth's death, including: whether policies, protocols, processes, and state laws were appropriately followed; what actions were taken after there were signs the youth was struggling with mental health problems; and, whether there were any gaps in current policies, procedures, or practice that limited the juvenile justice system's effectiveness.

Investigative Findings:

Probation imposed several alternatives to detention that differed from the type of restrictions listed in law or specified in policy and common practice.

By Nebraska law, whenever a law enforcement officer would like a youth placed in detention, Probation decides whether that youth should be placed in a secure detention facility, whether other restrictions on the youth's liberty should be imposed, or whether the youth should be released home without restriction based on the results of a standard tool, the Risk Assessment Inventory.[41]

Information for the assessment is gathered during what is referred to as an "intake interview" with the youth, law enforcement, and a parent or guardian.

Before a change in law in 2016, restrictions on liberty were referred to as "nonsecure detention" in statute, rather than alternatives to detention, and could include a range of placements as well as electronic monitoring and other supervision options.[42]

The Risk Assessment Inventory lists a range of alternatives to detention including placement

[41] *Neb. Rev. Stat.* §§ 43-250 (1)(c), 43-260, 43-260.01.

[42] *Neb. Rev. Stat.* § 43-245(17) prior to July 21, 2016. "Nonsecure detention means detention characterized by the absence of restrictive hardware, construction, and procedure. Nonsecure detention services may include a range of placement and supervision options, such as home detention, electronic monitoring, day reporting, drug court, tracking and monitoring supervision, staff secure and temporary holdover facilities, and group homes."

options and restrictions when a youth is returned to the custody of a parent, including: home detention/curfew; tracker; day/evening reporting; electronic monitoring; and other. However, no Probation policy or protocol currently exists to further clarify what options are appropriate or inappropriate for use as alternatives to detention.

In this case, the probation officer determined that the youth scored as being eligible to release home on restriction and imposed: electronic monitoring, tracker, zero curfew (only allowed to leave home for work, school, or errands with his parents), suspension of driving privileges, and no friends allowed at home.

The OIG found that two restrictions placed on the youth – suspension of driving privileges and limiting contact with friends – while not banned by law or policy, are not clearly authorized as supervision options in either law or policy.

There was some concern among Probation administrators interviewed that restrictions on driving and contact with friends were not completely appropriate or authorized.[43] Said one, "If it's a brand new kid straight off the street, not on Probation, those wouldn't typically be what would be considered as an alternative to detention. […] Those would be more the parent has to enforce that, because that's more of a parental role versus what we [Probation] have the authority to do."

Restrictions on driving or contact with friends are not mentioned as appropriate or possible alternatives in any law, policy, or document. The broad language in law and lack of Probation policy on the subject also means that Probation is not explicitly prevented from using these restrictions as alternatives to detention either.

The use of these restrictions on driving and friend contact became more problematic in this case since no detention hearing or court review was held between the time the youth had his liberties restricted and his death.

Indications that the youth had significant mental health problems were not addressed by Probation or the private service provider for tracker services.

There are no specific requirements in law, policy, or contracts that the OIG reviewed that require either Probation or the service provider to gather information on the mental health of youth with whom they are involved.

However, the OIG did discover through interviews that it is standard practice for probation officers to ask questions about mental health during intake interviews – including questions about suicidality and medication. Similarly, the service provider's standard tracker form gathers background information on any mental health diagnoses, treatment, medication, and names of professionals who may be involved in treating the youth.

Interviews also revealed that there are no requirements or guidance for either Probation or the service provider if it is discovered that a youth has mental health problems or may be at risk for suicide. According to staff and supervisors at both agencies, these issues tend to be handled on

[43] "Administrators" refers to Probation employees who have a range of management responsibilities at the local or state level. It does not refer to the position of Probation Administrator.

a case-by-case basis, or in the case of the service provider, if Probation makes a direct request that a tracker look into an issue or follow up on a concern.

In this case, the probation officer documented that the youth had a history that involved hospitalization for suicidal threats in the past year, drug and substance abuse evaluations, a diagnosis of intermittent explosive disorder, and that he had stopped taking his prescribed medications. All of these are suicide risk factors amongst adolescents.[44]

Interviews and documentation showed that none of the information Probation gathered on the youth's mental health was passed on to the service provider. Probation did recommend the youth get a substance abuse evaluation, but no referrals or suggestions for mental health services were made, nor was this suggestion shared with the service provider.

When the service provider conducted its own intake for the Tracker and Electronic Monitoring, concerning information about the youth's mental health and suicide risk was captured including: his recent psychiatric hospitalization, and a reported diagnosis of bipolar disorder, depression, and substance abuse disorder.

The prior hospitalization and substance abuse disorder are suicide risk factors. Among psychiatric disorders, diagnosed bipolar disorder has one of the highest risks for completed suicide. Individuals with depression diagnoses are also at higher risk for suicide.[45]

The provider got releases signed from the youth and his mother to receive copies of mental health records and speak with mental health providers. However, no steps were taken to coordinate with the youth's mental health providers because Probation had not requested it and the family was reluctant to have others know that the youth was involved with the juvenile justice system.

The concerns revealed in initial interviews could have triggered a push towards immediate mental health referral and treatment. However, neither Probation nor the service provider took action to ensure that the youth was appropriately assessed by a mental health professional.

The liberty restrictions placed on the youth by Probation contributed to his social isolation and perception of being a burden, both considered factors that could increase the likelihood of suicide.

National research has illustrated the links between mental health diagnoses, suicide risk, and the juvenile justice system. Youth in the juvenile justice system are more likely than their peers to have mental health and substance abuse diagnoses.[46] Risk factors for

[44] "Suicide and Suicide Attempts in Adolescents." Pediatrics: April 2000, Vol. 105, Issue 4. Committee on Adolescence: American Academy of Pediatrics. http://pediatrics.aappublications.org/content/105/4/871. See also: Bennett DS (1994) "Depression among children with chronic medical problems: a meta-analysis." J Pediatr Psychol 19:149–169.

[45] Goldstein, Tina R. "Suicidality in Pediatric Bipolar Disorder." Child and adolescent psychiatric clinics of North America 18.2 (2009): 339–viii. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2827306/ and "Suicide: Risk and Protective Factors." Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html.

[46] Skowyra, Kathleen and Joseph Cocozza. "Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System National Center for Mental Health and

suicidal ideation and behavior (including mental health diagnoses) are more common in juvenile justice populations.[47] Risk for adolescent suicide attempts has also been linked with social problems and stressors, including legal difficulties or court involvement.[48]

Academic and scientific research on suicide has not definitively identified a single set of factors that can explain or predict when and why suicide completion occurs. However, *the Interpersonal Theory of Suicide* is a well-regarded model that groups well-established risk factors identified through rigorous academic research into two driving forces that increase a person's desire to die.

Referred to as "thwarted belongingness" and "perceived burdensomeness," the *Theory* posits that when these factors are both present and accompanied by a heightened capability to commit suicide established through a history of prior attempts or extreme risky behavior, successful suicide attempts are especially likely. Thwarted belongingness refers to when a human being's fundamental need "to belong" is not met. This occurs when a person feels socially isolated or feels they do not have reciprocal, caring relationships. Perceived burdensomeness refers to a person's feeling that family members or loved ones would be better off without them. It is associated with shame.[49]

According to the private provider who saw or corresponded with the youth nearly every day for the 25 days leading up to his death, his involvement with the juvenile justice system contributed to feelings of shame and guilt. The service provider shared with the OIG that his family was distressed that they were involved with the juvenile justice system, "[… He] felt like he was already a burden and this was embarrassing for his family."

The alternatives to detention that Probation placed on the youth limited his ability to socialize with friends, and may have contributed to an overall sense of social isolation. The youth attended school online after being expelled from school and also took one class at a local Community College, a new environment for him.

Since he was no longer enrolled in public high school, he had no ability to see his friends in person at school. Thus, his contact with friends was greatly reduced in the 25 days before his death with both his zero curfew and ban on friends visiting the house. In the words of the tracker, "The kid had literally spent the entire past month at school or with his mom. […] No friends were allowed over [to the house], he couldn't leave, obviously."

Probation denied a request by both the youth and the service provider that he be allowed to attend homecoming or even take pictures with his girlfriend at home before the dance,

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Juvenile Justice." Washington, D.C.: National Center for Mental Health and Juvenile Justice, 2007. http://www.ncmhjj.com/wp-content/uploads/2013/07/2007_Blueprint-for-Change-Full-Report.pdf.

[47] National Action Alliance for Suicide Prevention: Youth in Contact with the Juvenile Justice System Task Force. (2013). Suicidal ideation and behavior among youth in the juvenile justice system: A review of the literature. Washington, DC. http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/JJ-5-R1-Literature-Review.pdf.

[48] "Suicide and Suicide Attempts in Adolescents" American Academy of Pediatrics.

[49] Van Orden, Kimberley et. al. "The Interpersonal Theory of Suicide."

since he had had no violations. According to the tracker, who established a close relationship with the family, and the law enforcement investigation into the death, an argument with his girlfriend over the phone, reportedly about homecoming, was the event that immediately preceded the youth's suicide.

Probation's supervision and monitoring of the youth after an alternative to detention was decided had no basis in Nebraska law or Probation policy, protocols, and processes.

Nebraska law does not address what role Probation plays once an alternative to detention has been imposed. The law does require that counties, not Probation, pay for all detention alternatives and services prior to adjudication, except for evaluations and non-detention placements.[50] Probation is not required to take any action after an alternative is imposed nor are they clearly banned from playing a role in the case.

Similarly, there is no Probation policy or protocol that addresses what role an officer should play in a youth's case between the time an alternative to detention is imposed and a court hearing where a judge can order certain services through Probation or place restrictions on a youth.

In July 2016, Nebraska law changed to require that youth who are placed on detention alternatives have a detention hearing within 24 hours, excluding non-judicial delays.[51] Prior to this, youth could be on alternatives for weeks without any clear framework in law or policy for how their case should be handled or who should be in charge.

Individual Probation Districts have some requirements for probation officers to communicate with the court or county attorney after imposing an alternative to detention. Probation administrators also told the OIG that officers are required to issue non-monetary vouchers to providers when setting up alternatives to detention services. Although Probation does not pay for these services, the provider inputs documentation into the Probation system, allowing Probation to monitor progress. However, no further guidance is given to officers.

According to some Probation administrators, when no one was tasked with monitoring youth cases between the imposition of alternatives and court, probation officers often stepped in during the period of time when liberty restrictions were put in place and an eventual court date. This period of time reportedly could last anywhere from a few weeks to a few months. There was no policy or procedure governing what their responsibilities were in these cases.

In this case, a review of the youth's Probation file and interviews with other Probation employees revealed that they did play a role that included monitoring and supervision. The probation officer completing the intake continued to receive reports on the youth's progress from the tracker and electronic monitor and weigh in on whether he could do certain things (e.g. – attend homecoming).

It was clear from interviews with the service provider and records reviewed that both youth and service provider believed that Probation was in charge of the youth's case after alternatives to detention were imposed and complied with officer decisions.

[50] *Neb. Rev. Stat.* § 43-290.01.

[51] LB894, effective July 21, 2016. *Neb. Rev. Stat*. § 43-253.

However, the probation officer had no explicit responsibilities or authority specified in law or policy to continue to monitor these records or make decisions related to the youth's restrictions.

OIG Recommendations and Agency Response:

The OIG made nine recommendations to Probation and two recommendations to the service provider based on the investigation findings.

Recommendations to Probation

The OIG recommended that Probation implement the following changes to address the issues identified in this case. In addition to clarifications to the findings and main body of the report, Probation requested modification on all recommendations without further comment on the content of the recommendations. The OIG made changes and clarifications to report findings, but after careful review, made no modifications to the recommendations.

I. Adopt statewide policy or protocol on what a probation officer's role is between assigning an alternative to detention and a court hearing.

Currently, there is no statewide policy or protocol governing what a probation officer's responsibilities are between the time a youth is assigned an alternative to detention and a court hearing. Standard processes in local probation districts are also lacking. Interviews indicate that practice seems to differ from county to county.

In this case, the lack of clear policy meant that it was up to individual officer judgment in how and when to be involved in oversight and monitoring of the youth. This led to the officer instructing the service provider and the youth that he could not attend homecoming, for example, although it is not clear or settled that the officer had the authority to do so. It also led to confusion about who was ultimately in charge of decisions regarding the youth's case. While the youth, his family, and the service provider all believed Probation was in charge, Probation staff told the OIG that their role was not clear in statute or policy and that they were not in charge.

The OIG recommends that Probation adopt a statewide policy on what the role of officers is between assigning an alternative and a court hearing. This will help standardize practice across the state and ensure that probation officers are acting within their authority. If Probation believes officers should not be involved in cases after assigning an alternative to detention, a policy is needed so that officers clearly understand that expectation and do not exceed their authority. If there is a role Probation wants officers to play (including issuing and reviewing non-monetary vouchers), policy should clearly articulate what this role is and what expectations exist for officers so that officers, providers, and families have a clear understanding.

II. Adopt policy that specifies what restrictions are not appropriate for use as an alternative to detention.

State law currently defines alternative to detention as, "a program or directive that increases supervision of a youth in the community in an effort to ensure the youth attends court and refrains from committing a new law violation. Alternative to detention includes, but is not limited to, electronic monitoring, day and evening reporting centers, house arrest, tracking, family crisis response, and temporary shelter placement."[52]

State law clearly gives Probation flexibility in determining alternatives to detention. Probation policy, protocol, and local processes do not currently provide any guidance on what types of restrictions are inappropriate for use as alternatives to detention.

In this case, administrators told the OIG that two of the alternatives imposed on the youth, restrictions on contact with friends and driving, were not something they considered as appropriate, indicating that those decisions should be up to parents. However, there is no policy specifying that these and similar restrictions are inappropriate for use as alternatives.

The OIG recommends that Probation create and adopt a policy clearly stating what types of liberty restrictions are not appropriate for use as alternatives, so that liberty interests of youth and parental decision-making responsibilities are respected.

III. Implement guidelines on when it is appropriate to use specific types of alternatives to detention.

Each Probation District has developed a detention alternatives continuum showing a probation officer's choices ranging from least restrictive to most restrictive. However, choosing which alternative or set of alternatives to impose is left to officer judgment. There are no state or local guidelines on when it may be appropriate or inappropriate to use specific alternatives. In this case, the youth was put on a high risk tracker, electronic monitor, and a "zero curfew" (not allowed out of the house except for school, work, and errands). The officer had no guidance on whether that high degree of supervision would be appropriate for the youth.

The OIG recommends that Probation develop guidelines for officers to use to help decide when specific alternatives are appropriate. This will ensure that the process of deciding on alternatives is as objective as possible and appropriately informed by risk, while still allowing individual officer judgment and accounting for unique circumstances.

IV. Require a simple mental health screening during intake interviews and select a uniform tool for officers to use.

The intake process is currently structured to assess a youth's risk to reoffend or failure to appear in court. Based on the risk level, Probation decides what types of alternatives to implement. Probation staff interviewed in the course of investigating this report indicated that mental health problems

[52] *Neb. Rev. Stat.* § 43-245 (3).

are frequently an issue during intake. However, officers have no standard way of assessing the severity of the issue or identifying what types of concerns may be present.

The OIG recommends Probation adopt a simple mental health screening tool for use during intake to better aide officers in identifying any concerning mental health problems or areas where immediate follow up or further assessment is needed. This will help identify youth with mental health problems, better inform Probation as it makes its detention decision, and expedite the process of connecting youth with needed mental health services, whatever the detention decision may be.

V. Adopt policy requiring officers to make and document mental health referrals if an intake interview suggests that the youth has mental health needs.

Probation officers are not required to take any action if their intake interview reveals that a youth has mental health needs. Staff indicated that they can and do request law enforcement take youth into protective custody if they are actively attempting to harm themselves.

However, most of the mental health problems that impact youth will not rise to the level of needing hospitalization. Nonetheless, these problems can severely impact youth and families, even if they are not an active danger to themselves or others at the time of intake.

The OIG recommends that Probation develop a policy that requires officers who discover that youth have mental health problems during an intake make appropriate referrals and help the family develop a plan for accessing mental health assessment and care. While Probation cannot compel families to follow through on suggestions, they can and should offer resources, make calls to mental health professionals already serving the youth to alert them to the new law violation, attempt to connect families to already existing resources (e.g. – the Family Helpline or Family Navigator program), and when appropriate, make calls to the Child Abuse and Neglect Hotline if a parent does not seem able or willing to get a youth necessary care. The OIG also recommends that Probation's policy require that any referrals and follow up actions be clearly documented in intake paperwork.

VI. Create an acknowledgment form for youth and parents after an alternative to detention is implemented that contains information on their rights and responsibilities.

In investigating this case, it became clear that there was not a full understanding of the youth's and family's rights or the role of Probation once alternatives had been imposed. Having information explained and distributed to the youth and the family would have ensured that they were well-informed on what they could expect based on where the youth was in the juvenile justice system process and who they could contact with concerns.

The OIG recommends that Probation develop a simple acknowledgement form for youth placed on alternatives and their families to sign that lays out clear information on what alternatives have been decided on, what they can expect while a youth is on alternatives, when a court hearing should take place, their right to an attorney in court, who they contact with questions, and what their rights are while alternatives are in place. The OIG recommends Probation give a copy of the form to the family and keep a signed copy in the file.

VII. Improve communication protocols between Probation and alternative to detention providers to ensure that key information on youth is appropriately passed on.

There is no standard protocol for what information should be passed on to alternative to detention providers. In this case, no information that Probation had gathered on the youth's mental health, prior offenses, family life, and recommendation for a substance abuse evaluation was passed on to the service provider. Instead, the officer only passed on information about what restrictions he was placing on the youth. This meant that the contractor not only missed some key mental health information, but also needlessly repeated many of the same questions that Probation had already asked the youth and his mother within a 24-hour timeframe.

The OIG recommends that Probation adopt a protocol to improve communication between providers of alternatives to detention and Probation, which includes a requirement to immediately share all intake paperwork with the provider to prevent duplication.

VIII. Collect and publish data on the length of time between alternatives to detention being assigned and a court hearing taking place.

Nebraska law was recently changed to require detention hearings whenever alternatives are imposed. However, no data is currently available on whether these hearings are occurring and how much time passes between an alternative being imposed and a detention hearing.

The OIG recommends that Probation collect and publish data on whether and when these hearings are taking place to ensure that youth do receive hearings in a timely manner, and that the law is being appropriately implemented across the different regions of Nebraska.

IX. Assess whether Probation has the authority to monitor alternatives to detention.

Nebraska law does not specify what role, if any, Probation can or should play in monitoring alternatives to detention. If Probation decides to move forward with a policy that allows officers to specifically oversee alternatives, especially before any court hearing, there may be changes to statute needed. The OIG recommends that Probation carefully assess current law to ensure Probation's role is clear with regard to alternatives to detention. After analysis, if changes in law are needed, those should be communicated with legislators to take action.

Agency Response to All Recommendations: Request Modification

"Due to the extensive corrections requested in my correspondence of December 15, 2016, the Administrative Office of Probation is requesting that modification be made to all of the recommendations included in the Office of Inspector General's investigation report [...]. The Administrative Office of Probation further notes this request is due to the lack of evidence in the report which would support the findings and recommendations contained within it."

Status Update on Recommendations I. through IX.: Incomplete

Probation requested modification of these recommendations, but provided no alternate suggestions. The OIG made changes and clarifications to the report's findings, but did not

modify the recommendation.

Probation provided a list of reports to the OIG on its juvenile justice efforts in response to a request for updates. No information in the reports was relevant to these recommendations.

Recommendations to the Service Provider

The OIG recommended that the private service provider, Owens Educational Services, Inc., implement the following changes to address the issues identified in this case. All recommendations have been accepted and implemented.

I. Adopt a policy that requires contact with mental health professionals already involved with a family when a family gives consent.

In this case, the service provider had been given permission by the family to contact mental health professionals who had recently treated him. However, they did not do so. This represents a missed opportunity to have had the youth's mental health evaluated by a professional and ensure he was getting appropriate treatment. If the service provider is going through the purposeful effort of gaining consent to contact mental health professionals, such contact should be swiftly followed up on.

The OIG recommends that the service provider require contact with mental health professionals by trackers when a family gives consent. This will ensure that mental health professionals treating the youth are aware of their client's law violations, which can be a warning sign of deteriorating mental health, medication side effects, or other issues that need professional assessment and treatment. It will also guarantee that youth, families, and the tracker have the opportunity to get the youth any and all appropriate care. This is especially important when Probation is looking to the service provider for communication and input.

Agency Response and Update: Accept

"We immediately implemented the recommendations set out by your office. We now require all of our Juvenile Service staff to contact and stay in communication with the youth's mental health professional(s) if we have a signed release from the family. [...] The recommendations made by the OIG were very taken very seriously and we felt were incredibly important to implement." [53]

Status Update: Complete

Based on the information provided by the agency, the OIG determined this recommendation had been fully implemented.

II. Implement training on suicide warning signs and prevention in youth.

The OIG's interviews with service provider staff indicated that there is currently little to no training available to staff on suicide warning signs and prevention in youth. In this case, and the case of

[53] Email correspondence, July 17, 2017.

most youth with trackers, the tracker is the person who has the most consistent contact with the youth and family. The OIG recommends that the service provider implement training on adolescent suicide and prevention for all tracker staff. This training should include information about situations that may make suicide more likely and warning signs, so that they can recognize concerns. It should also include information on what steps to take to keep youth at imminent risk safe and make any needed mental health referrals.

Agency Response: Accept

"On April 27th, 2017, we had Olivia Moser LIMHP, PLADC Mental Health Practitioner II come train our staff Company-wide on QPR (Question. Persuade. Refer.) training for suicide prevention. We also added this curriculum to our New Hire Training. [...] The recommendations made by the OIG were very taken very seriously and we felt were incredibly important to implement."[54]

Status Update: Complete

Based on the information provided by the agency, the OIG determined this recommendation had been fully implemented.

[54] Id.

Investigation Summary:

Death of a State Ward in a DHHS -Licensed Group Home

A 17-year-old state ward of the Office of Juvenile Services and resident of a group home licensed by the Department of Health and Human Services' (DHHS) Division of Public Health, was found unconscious and not breathing in a hallway. Group home staff performed CPR and called an ambulance, but the youth was pronounced dead shortly after arriving at the hospital. The autopsy found the youth's death was caused by pulmonary thromboembolism, blood clots traveling from the legs to the pulmonary artery in the lungs.

The report examined: whether the group home appropriately responded to the youth's health care needs and conditions; whether rules, regulations, policies and procedures related to health emergencies and medical care were followed and whether they were sufficient; and, whether the Division of Public Health responded appropriately when the youth's death was reported.

Investigative Findings:

The group home's response to the youth's health emergency was reasonable.

Nebraska regulations require group homes to have access to both appropriate medical care and emergency care around the clock.

Beyond fulfilling the minimal licensing requirements related to medical emergencies, the OIG found that group home staff's response to the youth's medical crisis was reasonable.

When staff were alerted by another resident that the youth was lying in the hallway, they immediately went to check on her. At that time, the youth got up off the floor unassisted and the staff encouraged her to rest in her room. Twenty-five minutes later staff returned to check on the youth and discovered her in the hallway unconscious and not breathing. They immediately called for an ambulance, began CPR, and notified the youth's guardian responsible for medical decisions - the Division of Children and Family Services (CFS).

The youth's overall health care was not well documented or well-coordinated while at the group home.

Licensing regulations currently require that group homes have access to a complete medical record for children in their care, although this can be maintained by someone else. Facilities also must ensure that each child receives a physical and dental appointment within 14 days of admission.[55]

Further, there are requirements a child's individual group home record contain medical information, including, "[...]

2. Name, address, and phone number of the child's physician; [...]

4. Past (if available) and current immunizations;

5. Significant health problems (if available);

[55] 474 NAC 6-008.06: Health and Safety Requirements.

6. Emergency medical treatment; [...]

8. A comprehensive record of his/her development while in the facility."[56][2]

Regulations do not contain further specifics about what documentation is necessary to show that medical visits occurred or access to medical records is available, or how information on medical conditions should be maintained.

The only required pieces of information that were missing from the records available to the OIG were a full name and contact information for a physician and a copy of current immunizations.

However, the OIG also found group home records contained limited information on the extensive amount of health care she did receive while a resident. These records also failed to document some persistent health issues the youth was experiencing at the group home.

After the youth's death, both CFS and law enforcement conducted an investigation. Interviews with youth and staff at the group home as part of those investigations show that the youth had been experiencing dizziness and shortness of breath for a few weeks leading up to her death. The OIG's interviews with staff also indicated that she was suffering from headaches. However, there were no notes in written records that any of these issues were occurring.

The youth was on three different prescription drugs at the group home, two of which were psychotropic, and also received a birth control shot. Many of the youth's symptoms were possible side effects of medications that she was taking.

While group home records indicated that the youth had numerous medical appointments with primary care provider and a psychiatrist managing medications in the weeks leading up to her death, there was little to no information recorded on what occurred at these visits in group home records. It was not possible to verify whether the complaints about headache, dizziness, or shortness of breath had been mentioned to or addressed by providers. Any of these appointments would have been important opportunities to discuss these concerns.

The OIG found that there was no record of when and how the medications the youth was taking were administered by staff. Due to the lack of records, it was not possible for the OIG to determine whether the youth was taking her medication appropriately while at the group home or whether staff noted any side effects.

The OIG also found no record of attempts to coordinate about the medical care the youth was receiving with either CFS, the legal guardian at the time, or her parents. This lack of coordination included a specialist appointment that never took place that the youth indicated was supposed to address her headaches and vision problems.

While these issues were not violations of rules and regulations, they are concerning and relevant to how the youth's health care was managed. They also represent possible missed opportunities to address the youth's overall health needs.

[56]474 NAC 6-008.14: Records.

Licensing requirements and regulations related to medical care are currently not sufficient to ensure that children in group homes receive appropriate medical care.

In 2013, the Children's Residential Facilities and Placing Licensure Act, with additional requirements for facilities and Public Health, passed the Legislature and went into effect.[57]The new law was not fully implemented before the youth's death.

However, the law now allows Public Health to take action against facilities for, "Failure to comply with or violation of the Medication Aide Act," which governs administration of medications by caretakers.[58]

The Act also authorized Public Health to adopt rules and regulations that, "establish [...] standards for levels of care and services which may include, but are not limited to, [...] medical, and physical needs of children residing in or being placed by a residential child- caring agency [...]."[59]

Although a more rigorous set of laws is in effect, Public Health regulations governing licensure for Child-Caring Agencies have not been updated in over a decade. Most regulations were adopted in 2001, with some sections added in 2002, 2003, and 2004.[60] These regulations were promulgated under Public Health's foster care licensing ability, Neb. Rev. Stat. §71-1901-71-1907.

Current requirements related to medical care for group homes are fairly minimal. The OIG reviewed licensure standards for group homes in neighboring states, including Iowa, Kansas, and Colorado, as part of its investigation.

The OIG found other states had detailed requirements missing from Nebraska regulations related to: dispensing and monitoring medications and possible side effects; medical record keeping and timelines for retrieving medical documentation; copies of medical consents for treatment and the process for getting consent for treatment; reporting medical concerns and incidents to licensing authorities; and training and policies for staff related to medical emergencies and performing CPR.[61]

In interviews with current and former Public Health staff, the current regulations were described as, "very outdated," "not comprehensive," and "very old, old, old."

Public Health began drafting new regulations in 2013, but there has still not been a public hearing and one current staff member indicated that, "I think we're still a pretty long ways out [from adoption], but we've done a lot of work on them."

Staff indicated that the current regulations, which have limited requirements for group homes, make it very difficult to uphold standards that are in the best interests of

[57] LB265 (2013).
[58] *Neb. Rev. Stat*. § 71-1940 (8).
[59] *Neb. Rev. Stat*. § 71-1949 (2).
[60] 474 NAC Chapter 6.

[61] "Licensing Standards for Residential Placement Facilities." National Resource Center for Family-Centered Practice and Permanency Planning. Hunter College School of Social Work: August 28, 2008. http://www.hunter.cuny.edu/socwork/nrcfcpp/downloads/policy-issues/Licensing_Standards_Residential_Placement_Facilities.pdf.

children's health, safety, and well-being. One staff member who had been responsible for inspecting group homes described the situation in the following way: "They [the regulations] just weren't working. It was hard to cite people for things because there wasn't a regulation to cite them with. We always have to be able to defend, if we're substantiating anything and if we didn't have enough proof or if the regulation didn't say you have to do it this way, we couldn't do it."

Public Health staff indicated that some specific additions had been identified for inclusion in the new regulations including CPR training, more details on record keeping, and medication management: "When you've got large groups of kids with staff, you just need to make sure that they [the staff] know what they're doing, especially in terms of medication. It [the proposed regulation change] really is preventative."

Based on analysis of interviews with Public Health staff, a review of other state's regulations, and a review of this case, it is clear that current regulations, the same that were in effect at the time of the youth's death, are not sufficient to ensure that children living in group homes receive appropriate medical care.

The Division of Public Health's investigation after the youth's death was not thorough.

Currently, there is no requirement that facilities notify Public Health when a death occurs. Similarly, Public Health staff told the OIG that currently they do not have a formal, written process for reviewing deaths that occur at facilities.

Staff indicated that standard practice after a death is to coordinate with both law enforcement and CFS to determine what is being done and whether the Public Health review needs to wait or can be conducted collaboratively and simultaneously. Staff told the OIG, "If we can work together, that's what we prefer."

Current Public Health staff also indicated that it is common to gather supporting documentation from the facility about the incident and review reports from other agencies. Public Health may wait for autopsy results before deciding what steps to take. Staff indicated that they will review the incident for any possible violations of licensing rules and regulations.

Depending on whether there are possible violations of regulations, a broader investigation, which can (but does not always) include a site visit and conducting additional interviews, can be opened. In addition to assessing whether regulations were violated, staff told the OIG that they coach facilities on possible improvements.

Public Health reviewed this youth's death to assess compliance with two regulations - one about staff qualifications, requiring staff to be capable of performing required duties; and one about adequate staffing ratio to ensure children are supervised.

The Public Health employee who conducted the death review indicated that the staff qualifications regulation was often used, "as a coverall," due to the lack of specificity in the regulations in general which made it difficult to hold facilities accountable or enforce minimum care standards.

Public Health concluded that neither of the two regulations had been violated by reviewing CFS' out of home assessment (which had not found abuse or neglect), a copy of the law enforcement investigation

narratives (which had found no criminal wrongdoing), and the youth's autopsy.

The OIG did not find anything to dispute Public Health's findings related to staff qualifications or ratio. However, the Public Health review of the death was not thorough.

First, the scope of the review failed to look into whether regulations related to the medical care were violated, even though the cause of her death was a medical issue. Second, Public Health used only minimal documentation to complete its review. From available information it also appears that Public Health did not retrieve or review any of the group home records. No independent interviews with staff or youth to assess regulation compliance were conducted.

When the OIG reviewed the group home's compliance with medical regulations in this case, issues with documentation were uncovered. Group home records lacked the required information on immunizations and doctor contact information.

Had Public Health examined additional documents or broadened the scope of its review, they may have found these regulation violations and could have encouraged the group home to take corrective action. The limited scope of the review also meant that there was not an opportunity to provide technical assistance to better ensure that youth receive adequate medical care.

OIG Recommendations and Agency Response:

The OIG made five recommendations to the DHHS Division of Public Health. DHHS accepted all five recommendations.

I. Promulgate rules and regulations related to the Children's Residential Facilities and Placing Licensure Act as soon as possible.

The *Nebraska Administrative Procedures Act* (APA) requires that a, "public hearing on a rule or regulation that is required to be adopted, amended, or repealed based upon a legislative bill shall be held within twelve months after the effective or operative date of the legislative bill."[62] The APA further requires that an agency, "adopt and promulgate such rules and regulations within one year after the public hearing."[63] Although draft regulations have been prepared and shared with stakeholders for input (also known as the rule drafting period), Public Health has yet to continue on with the next step, holding a public hearing, to adopt regulations pursuant to the *Children's Residential Facilities and Placing Licensure Act*, which became effective May 25, 2013.

The OIG recommends DHHS finish the process of promulgating rules and regulations related to the Act as soon as possible. This would both ensure compliance with the APA and replace outdated and insufficient regulations with those that better can enforce the safety and well-being of Nebraska children in out-of-home placements. Moving forward on these new regulations is one of the most

[62] *Neb. Rev. Stat.* § 84-907.
[63] *Neb. Rev. Stat.* § 84-901.01.

important things that could be done to improve both Public Health licensing operations and residential facilities' ability to care for youth.

Agency Response and Update: Accept

"The DRAFT regulations for Residential Child Caring/Child Placing went through an extensive stakeholder review process. Licensees had many opportunities to provide input. Staff from the OIG were given the opportunity for input. The regulations are currently pending public hearing."[64]

Status Update: Incomplete

The OIG has determined this recommendation is incomplete. Public Health began developing draft regulations over two years ago. The current draft regulations have not yet been sent to the Secretary of State, the first step in the rules and regulations process. It is unclear when and if this will occur.

II. Include requirements related to dispensing and monitoring medications, especially psychotropic medications, in new regulations for Residential Child-Caring Agencies.

In this case, the OIG found that group home record keeping on the multiple prescriptions the youth was taking leading up to her death was extremely limited. This made it impossible to determine whether her medications were being distributed appropriately and whether some of the issues she experienced at the group home (dizziness, shortness of breath, headaches), might have been medication side effects. While none of these issues violate current Public Health regulations, the OIG believes that this gap in regulations must be addressed.

In the draft regulations that Public Health had developed and posted in December 2016, the agency includes important requirements for dispensing and monitoring medications that are not in current regulations. These include: training and registration as Medication Aides for staff distributing medications; clarifying requirements under the Medication Aide Act; and, additional requirements for medication record keeping, access and storage. The OIG recommends these additional requirements be included in the final, adopted version of regulations.

The OIG also recommends that Public Health add additional guidance specifically on psychotropic medication monitoring and oversight, given the risks these medications can pose to adolescents and the prevalence of their use for youth who are in out-of-home care through the child welfare and juvenile justice systems. The OIG recommends that Public Health require that possible side effects of prescribed medications be communicated to the residential facility upon arrival or intake. Youth experiencing any such side effects while at the residential facility, as well as any medication impact on the youth's overall mood and behavior, should be documented and shared with the prescribing provider by staff distributing these medications.

Agency Response and Update: Accept

"Proposed language regarding dispensing and monitoring:

[64] Memorandum, Aug. 23, 2017.

006.17 MEDICATION. Any staff providing prescription or non-prescription medication must do so in accordance with the "Five Rights" as set out in the Medication Aide Act (Neb. Rev. Stat. §§71-6718 – 71-6743.

> 006.17(A) DIRECTION AND MONITORING. Prescription and non-prescription medication must be directed and monitored by a parent or guardian or a Licensed Health Care Professional.
>
> 006.17(B) STAFF REQUIREMENTS FOR PROVIDING MEDICATION. When prescription and non-prescription medications are not provided by a parent or guardian or a Licensed Health Care Professional, they must be provided by a staff who, as verified by documentation:
>
> > 1) Is a registered as a Medication Aide pursuant to Neb. Rev. Stat §§ 71-6718 to 71-6743; or
> >
> > 2) Has been determined by the Executive Director to be competent to give or apply medication.
> >
> > > 006.17(B) (i) ACCESS TO MEDICATION. Only staff authorized by the executive director of the residential child-caring facility and who meet the criteria in 006.17(A) or 006.07(B) may have access to medications.

The proposed regulations meet the intent of the OIG recommendations. No matter what medication a child/youth may be taking, staff at the program can only give or apply medication as directed by parent or guardian. If special circumstances apply and special monitoring must occur, that must be included in the documented written instructions for the medication, including any psychotropic drugs."[65]

Status Update: Incomplete

The OIG has determined this recommendation is incomplete. The current draft regulations do propose standards on medication management, but have not yet been sent to the Secretary of State, the first step in the rules and regulations process. It is unclear when and if this will occur.

III. Adopt clear requirements on medical record-keeping and documentation in regulations.

The group home's records related to the medical care and symptoms of the youth while she was a resident contained minimal information. Some missing information was required by rules and regulations, but some of the information that would be the most essential (complete recent medical history, documentation of all medical visits and care provided at the group home) was not. The OIG recommends that this gap in requirements be addressed by adopting more detailed regulations.

Draft regulations do address some of the issues with medical records and documentation by adding requirements for: adopting detailed policy on how complete documentation of medical needs, medication, and allergies, and medical and dental exams for the 12 months prior to admission will be obtained; and, keeping records of all medical exams, illnesses, treatments, and immunizations,

[65] Id.

including mental health evaluation and treatment. The OIG urges that these clarifications be included in the final, adopted version of regulations.

The OIG also recommends further clarifying what constitutes an "illness" and "treatment" that should be documented in regulations. The OIG recommends that even what might seem like "minor" issues youth report to staff – like headaches or momentary dizziness – and that even small treatments – like bandaging cuts and abrasions –be documented by facilities.

Agency Response and Update: Accept

"Proposed language regarding recording keeping/documentation:

> 006.17(E) MEDICATION RECORD KEEPING. A written record must kept separately for each child and be available for review by the Department. For any prescription or non-prescription medication provided to a child the record must include the:
>
> 1) Name of the child;
> 2) Name of the medication;
> 3) Amount or dosage;
> 4) Route the medication is provided;
> 5) Time medication is provided; and
> 6) Name of staff person responsible for providing the medication.
>
> 006.17(E) (i) MEDICATION ERRORS. Medication errors must be clearly documented and reported to the child's parent or legal guardian.

The proposed regulation change meets the intent of the recommendations. Currently, programs are not required to maintain any type of documentation for youth in care. Proposed regulations would require programs to develop detailed written policies and procedures regarding how they will assess and address the immediate needs of the child in care and what specific medical needs the child or youth may have at the time of admission. Proposed language also requires programs to have documented proof of children receiving, 'necessary treatment for any physical or mental health care needs.'"[66]

Status Update: Incomplete

The OIG has determined this recommendation is incomplete. The current draft regulations do propose some standards on record keeping, but have not yet been sent to the Secretary of State, the first step in the rules and regulations process. It is unclear when and if this will occur.

IV. Clarify requirements for consents for medical care, treatment, and coordination for Residential Child-Caring Agencies in regulations.

Much of the health care the youth received leading up to her death was arranged by the group home, which had received an agreement from CFS to obtain health care for her. Current regulations do require agreement for the child to be provided medical treatment and care (including in emergencies) be provided for a youth on admission. However, there are no further specifications as

[66] Id.

to what kinds of treatment this must cover or when communication with the guardian on medical decisions is necessary. There are also no requirements on what role the group home should play to coordinate care with the youth's medical provider and guardian.

In this case, a review of medical files and interviews with group home staff indicate that while they were arranging some treatment and appointments, it was unclear who was ultimately responsible for medical decisions, following up on identified health needs, and communicating and coordinating with the medical providers that the group home arranged to have the youth see.

The OIG recommends that DHHS include a requirement that Residential Child-Caring Facilities not only adopt policy on how they will obtain consent for treatment, but also adopt policy on what that consent should entail, when consultation with guardians must occur, and how medical care and decision-making will be coordinated between the facility, guardian, and all medical professionals providing treatment.

Agency Response and Update: Accept

"This is the proposed language regarding medications in the Residential Child Caring Regulations regarding consent for medical care and treatment:[67]

006.12 ADMISSION POLICY AND PROCEDURE REQUIREMENTS. Acceptance of a child must be based on the assessment and not on the race, color, national origin or special health care needs of the child. Detailed written policies and procedures must include how the facility will:

1) Assess and address the immediate needs of a child;
2) Review admission information and makes admission decisions, including which staff are responsible;
3) Assess its ability to meet the needs of the child based upon staff capacities, the facility/service/program structure, and available community services.
4) Identify special health care needs which the agency is not able to meet;
5) Obtain written information for a child's record to include:
    a) Full name;
    b) Date of birth;
    c) Date of admission;
    d) When applicable, a referral from the child placing agency;
    e) Legal custodian;
    f) Consent of the legal custodian for placement or a copy of the approved Interstate Compact on the Placement of Children (ICPC) agreement;
    g) Written documentation of complete medical and dental examinations current within the past year;
    h) Consent from the legal custodian for medical, dental, vision and emergency treatment;
    i) Medical needs, medications, and allergies, including food allergies and dietary restrictions;
    j) A list of persons with whom the child may have contact.
    k) An inventory of personal items to be updated as the inventory changes.

[67] DHHS provided the highlights to indicates the parts of the proposed regulations pertained to the recommendation.

6) Orient the child to the facility which will include:
   a) A tour;
   b) Introduction to staff;
   c) Description of rules, regulations, and discipline policies;
   d) Discussion of tasks and behaviors the child is expected to perform; and
   e) Discussion regarding personal possessions the child is permitted to have.

006.13 CHILD INFORMATION/RECORD. The child's record must contain the information required at the time of admission (006.12 Item 5) and the following:

1) Current educational information including: grade reports, scholastic achievement and social adjustment;
2) Medical, dental, and vision records including: examinations, immunizations, illnesses, and follow-up treatments;
3) Psychological or psychiatric testing, examination, and follow-up treatment, if obtained;
4) Visits to the child and contacts with child's own family and services provided or arranged;

During the stakeholder workgroup meetings, the suggestion for some type of "Compliance Guide" or some type of guidance documented was offered. Licensees were very receptive to that idea. More specific guidance regarding what should be included in policies/procedures related to medical treatment coordination would be beneficial to include in that guidance document. The basic requirement for seeking medical treatment would be part of the regulation, but how that treatment needed to be described in their policy/procedures could be part of that guidance."[68]

Status Update: Incomplete

The OIG has determined this recommendation is incomplete. The current draft regulations do propose some standards on consent for medical care, but have not yet been sent to the Secretary of State, the first step in the rules and regulations process. It is unclear when and if this will occur.

V. Increase coordination with the Division of Children and Family Services and Administrative Office of Probation on Residential Child-Caring Agencies.

Although the youth in this case was a state ward through the Office of Juvenile Services, many of the youth placed in facilities in Nebraska are now supervised by Probation. The DHHS Division of Children and Family Services (CFS) is also the guardian of some youth in these facilities. In some instances, both entities are involved.

Interviews with Public Health and facility staff during this investigation revealed that there is often confusion on the part of facilities, and amongst state agencies, as to what Public Health's role and requirements are relative to CFS and Probation. CFS and Probation have their own requirements for facilities through contracts and voucher requirements, and facilities do not always understand that licensing requirements apply to all youth in the facility regardless of which agency is paying for their placement. Facilities may be unintentionally receiving incorrect information from CFS and Probation about licensing standards.

[68] Id.

The OIG recommends that Public Health increase coordination with CFS and Probation related to Residential Child-Caring Agencies. There may be ways to improve communication between agencies to better clarify questions that facilities have about standards, especially once the new, more extensive, regulations are in place. There may also be ways to better share information about concerns at facilities and provide technical assistance and coaching to facilities who may not be providing optimal care to the challenging youth population that they serve.

Agency Response and Update: Accept

"The Licensure Unit has consistent contact with staff from Children and Family Services and Office of Probation. In the past year, a joint visit between CFS and the Licensure Unit was made to a Residential Child Caring Agency that was experiencing compliance issues. It was beneficial for the program to see both arms of the agency have a united message. The Inspection Specialist responsible for the licensure of Residential Child Caring facilities routinely conducts joint investigations with CFS workers in those cases of alleged abuse/neglect cases. Information about licensed facilities is shared between the entities that include any placement concerns, ongoing investigations, and results of investigations. All entities have made a commitment to continue to work on coordinated efforts."[69]

Status Update: Progress

Based on the information provided by Public Health, the OIG determined that progress towards implementation of the recommendation has been made. Additional steps to enhance collaboration and communication are planned.

[69] Id.

Investigation Update:
Sexual Abuse of State Wards, Former State Wards, and Youth Placed in Residential Facilities

The OIG has received numerous reports of sexual abuse of children while they are in the state's care -- as a state ward, a former state ward in a guardianship or adoptive home, or while placed at a licensed facility. During the past year, the OIG opened an investigation into whether DHHS was taking sufficient action to prevent and respond to the sexual abuse of these youth in the child welfare and juvenile justice system. The investigation included a review of both the operations of the Division of Children and Family Services (CFS) and the Division of Public Health's Children's Services Licensing Program.

The OIG publically announced its investigation in December 2016. The investigation was primarily conducted between January and June 2017. In the course of the investigation, the OIG:

1. Reviewed hundreds of pages of documentation provided by DHHS, local police departments, and private providers;
2. Conducted 54 interviews and three site visits to gather additional information and evidence;
3. Identified victims of substantiated cases of sexual abuse who were state wards, placed in DHHS-licensed facilities, or sexually abused in the adoptive or guardian homes in which the state had placed them; and,
4. Identified systemic issues and recommendations for improvement.

During the 2017-18 fiscal year, an investigative report was presented to the Public Counsel and then presented to DHHS in accordance with the OIG Act.[70] The investigative report will be final in the fall of 2017, after responses have been received and all necessary modifications are addressed. A summary of the final report may be made public according to the new process established in the OIG Act.[71] The OIG's 2017-18 annual report will include a summary of the report.

[70] *Neb. Rev. Stat.* § 43-4327.
[71] *Neb. Rev. Stat.* § 43-4325.

Appendices

Appendix A: Status of Recommendations

Appendix B: Office of Inspector General of Nebraska Child Welfare Act and Other Relevant Statutes

Appendix A. OIG Recommendations and Implementation Status

The table below contains a summary of 63 recommendations that have been made by the OIG to agencies in investigative reports and their implementation status as of the publication of this report.

The recommendations are numbered based on the year and order the recommendation appeared in an OIG Annual Report. For example, the first recommendation appearing in the 2015 Annual Report is numbered 15-01. Some recommendations were made to more than one agency.

Each recommendation is assigned an implementation status by the OIG based on information provided by the subject agency. The definitions of each status are:

- **Rejected:** The agency rejected the recommendation as part of the original investigation.
- **Incomplete:** The agency has not taken relevant action to address the recommendation.
- **No Further Action:** The agency has taken some relevant action to address the recommendation, but has no plans to take additional necessary action to fully address the recommendation.
- **Progress:** The agency has taken relevant action to address the recommendation and has plans to take additional necessary action to address the recommendation.
- **Complete:** The agency has taken all relevant and necessary action to address the recommendation.

Of the OIG's recommendations:

- Thirteen recommendations were made to the Administrative Office of Probation (Probation). Of the recommendations, four were rejected and nine are incomplete.
- Forty recommendations were made to the DHHS Division of Children and Family Services (CFS). Of the recommendations, 21 are complete and eight are in progress. Four recommendations are incomplete, one recommendation was rejected, and six have been categorized no further action.
- Seven recommendations were made to the DHHS Division of Public Health (Public Health). Three are in progress, and four remain incomplete.
- Two recommendations were made to the DHHS Division of Developmental Disabilities. Both recommendations are complete.
- Four recommendations were made to private agencies. All four recommendations are complete.

OIG Recommendation	Agency or Agencies Responsible	Implementation Status
15-01. Adopt federally mandated mental & behavioral health policies.	DHHS - CFS	**No Further Action** In April 2016, DHHS adopted most required policies, including use and oversight of psychotropic medications and guidelines on updating medical information. These have been updated and are currently found in Protection and Safety Procedure #13-2017. DHHS does not plan to adopt a mental health or trauma screening tool. DHHS will use the Family Strengths and Needs Assessment for this purpose. However, there is no guidance given to staff on how this tool can be used as a trauma or mental health screening.
15-02. Expand training on mental and behavioral health.	DHHS - CFS	**Complete** DHHS has added in-service training on these topics, and added suicide prevention training to topics covered in New Worker Training. In July 2017, an updated mental health desk aid was made available to all staff.
15-03. Expand quality improvement and assurance related to mental and behavioral health and psychotropic medications	DHHS- CFS	**Complete** DHHS updated its N-FOCUS system in March 2015 to allow for easy record keeping on medications, health care appointments, and medical conditions. Information entered is now reviewed by administration and at Continuous Quality Improvement (CQI) meetings.
15-04. Improve Home Study Process	DHHS-CFS	**Progress** An updated draft home study template and draft quality assurance tool were developed in 2017 and are being reviewed internally.
15-05. Provide stronger supports for kinship and relative foster families	DHHS-CFS	**Progress** Significant changes to how kinship and relative foster homes are supported are currently underway. DHHS is planning to hire and train 14 kinship specialists placed in offices across

OIG Recommendation	Agency or Agencies Responsible	Implementation Status
		the state to help support these homes. This change to providing support internally for some homes is in response to budget cuts. DHHS has also contracted with the Nebraska Foster and Adoptive Parent Association to provided specialized training, Kinship Connection, across the state.
15-06. Ensure "Absence of Maltreatment in Foster Care" is as accurate as possible	DHHS-CFS	**Complete** Since May 2016, DHHS has listed 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.
15-07. Develop and provide training to frequent reporters and law enforcement on Child Abuse and Neglect Hotline.	DHHS-CFS	**No Further Action** 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, developed with DHHS assistance. DHHS provides training on child abuse reporting and the hotline to groups on request. No training for other frequent reporters – schools, medical professionals, etc.– has been produced or made easily available. DHHS has no current plans to expand training efforts.
15-08. Create a protocol for asking for and receiving photos at the Child Abuse and Neglect Hotline.	DHHS-CFS	**Complete** In February 2016, DHHS adopted Protection and Safety Procedure #5-2016, "The use of Photographs from Intake through Case Closure."
15-09. Assess availability of training, information, and	DHHS-CFS	**Progress**

OIG Recommendation	Agency or Agencies Responsible	Implementation Status
programs designed to prevent child abuse within immigrant communities.		DHHS is currently participating in an Environmental Scan of prevention programs through the Bring Up Nebraska Initiative. Specific information will be gathered on child abuse prevention needs and services in immigrant and refugee communities.
15-10. Adopt and implement standards for transporting youth to and from the Youth Rehabilitation and Treatment Centers.	DHHS-CFS	**Complete** On July 1, 2017, DHHS's "Secure Transportation" service definition for transport to and from YRTCs became effective.
15-11. Increase and improve resources, tools, and support for PREA implementation at YRTC-Geneva.	DHHS-CFS	**Complete** In July 2015, a full-time Central Office PREA Manager position was created to oversee PREA implementation at both YRTCs. In 2016, a compliance team that oversees PREA and other key issues at both facilities was put in place. OJS is currently planning for the next round of PREA audits.
15-12. Provide increased guidance for culture change at YRTC-Geneva	DHHS-CFS	**Complete** In the fall of 2016, daily calls between the facility and OJS administrator, as well as the compliance team of both facilities were put into effect. Work is ongoing to standardize processes and policies at both YRTCs. Changes have been made to YRTC-Geneva's organizational structure to allow the psychologist to directly supervise therapists.
15-13. Make clarifications to policies governing sexual abuse and harassment at YRTC-Geneva	DHHS-CFS	**Complete** In August 2015, DHHS updated Administrative Regulation 115.17 to clarify reporting of incidents, investigation protocol, training, and other PREA-related topics. YRTC-Geneva made changes to OM

OIG Recommendation	Agency or Agencies Responsible	Implementation Status
		115.17.5 in August 2015 to clarify facility specific policy and procedure. Work to standardize policies and procedures at both YRTCs is ongoing.
15-14. Clarify Hotline policy and procedure when receiving a report of sexual assault	DHHS-CFS	**Complete** The Hotline updated its guidebook and also gave staff direction and reminders on selecting the correct law enforcement agency. The OIG reviewed intakes about YRTC-Geneva for the 2016-17 fiscal year and identified only one error.
16-01. Implement training on the medical aspects of child abuse.	DHHS-CFS	**Progress** The Center for Children, Families, and the Law (CCFL), which provides training for DHHS, added material on the medical aspects of child abuse to its curricula in January 2016. It contracted with a pediatrician to review this training curricula in August 2017. Based on this professional review, additional changes are possible.
16-02. Adopt policy on photographing injuries during Initial Assessment.	DHHS-CFS	**Complete** In February 2016, DHHS adopted Protection and Safety Procedure #5-2016, "The use of Photographs from Intake through Case Closure."
16-03. Develop additional training for Initial Assessment staff.	DHHS-CFS	**Complete** CCFL updated its New Worker Training in 2016 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 being offered around the state.

OIG Recommendation	Agency or Agencies Responsible	Implementation Status
16-04. Further define process for utilizing child advocacy centers by Initial Assessment.	DHHS-CFS	**No Further Action** After consulting with DHHS legal staff on expanding requirements on the use of Child Advocacy Centers,DHHS decided not to 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. DHHS indicated they did not believe the burden for referral should be on DHHS staff alone. DHHS issued a revised memo on use of CACs, Protection and Safety Procedure #23-2017, however, none of the OIG's suggestions were incorporated.
16-05. Update and provide additional detail on response priority definitions.	DHHS-CFS	**Complete** DHHS updated its intake manual in August 2017 in Protection and Safety Update #26-2017. The updated manual provides clarification on priority response time definitions involving injuries to children under age six.
16-06. Conduct an analysis to determine whether supervisory staffing at the Hotline is adequate.	DHHS-CFS	**No Further Action** In September 2016, new guidelines for supervisory review of intakes (calls to the Hotline) went into effect, reducing the percentage Supervisors had to review and extending the timeframe for them to complete reviews. These changes were implemented, but no analysis of supervisory staffing occurred nor did a review of all of their responsibilities. DHHS has no plans to do so.
16-07. Expand quality assurance and continuous quality improvement (CQI) at the Hotline.	DHHS-CFS	**Progress** DHHS is just beginning to review additional Hotline calls related to physical

OIG Recommendation	Agency or Agencies Responsible	Implementation Status
		abuse allegations of children under six on a quarterly basis.
16-08. Increase the Initial Assessment workforce to comply with Nebraska law on caseload standards.	DHHS-CFS	**Incomplete** DHHS 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 see if they could be repurposed as case managers. However, DHHS is still out of compliance with caseload standards and has no projection of when they will be met.
16-09. Take steps toward greater Initial Assessment workforce specialization and experience.	DHHS -CFS	**Incomplete** DHHS reports that it is not possible to specialize the Initial Assessment workforce in many rural parts of the state. DHHS has enhanced training for workers assigned to Initial Assessment, however no other steps have been taken.
16-10. Contract with an independent entity to perform a validation study of Nebraska's SDM Risk Assessment instrument.	DHHS-CFS	**No Further Action** DHHS contracted with the National Council on Crime and Delinquency to conduct independent case reads on SDM safety and risk assessments. The results of the case reads were fairly positive. However, this was not a validation study. There is still no research demonstrating whether Nebraska's SDM tool is accurately predicting risk or not and whether adjustments to the tool may need to be made.
16-11. Gather and analyze additional data on the prevalence of pediatric abusive head trauma and update shaken baby syndrome materials.	DHHS - Public Health	**Progress** The Child Safety Collaborative Innovation & Improvement Network (CoIIN), housed at Public Health, has developed a Crying Plan pilot project and is gathering data from Hospitals on the materials they distribute and education they provide on shaken baby syndrome.

OIG Recommendation	Agency or Agencies Responsible	Implementation Status
16-12. Increase the capacity for the child welfare workforce to participate in pediatric abusive head trauma prevention efforts.	DHHS-CFS	**Complete** 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. CFS Staff are encouraged to give out the information anytime they assess or work with a family with a very young child.
16-13. Increase the number of supervisors at the Child Abuse and Neglect Hotline and assess Hotline workload and ongoing training and supervision.	DHHS-CFS	**Incomplete** In 2016 and 2017, DHHS devoted resources to studying and improving processes at the Hotline.
16-14. Enhance data available on Initial Assessment and mixed caseloads at Central Office and make this information publically available on a monthly basis.	DHHS-CFS	**Incomplete** The CFS Quality Assurance team is currently testing a new workload tool to assist with case assignments. Data is not yet available on the tool or its processes. Data from the tool would not capture information on whether DHHS is complying with statutory caseload requirements.
16-15. Collect data on high and very-high risk cases that do not accept services and implement more promising approaches to family engagement.	DHHS-CFS	**Progress** DHHS has collected data on high and very-high risk families declining services, is reviewing the data, and contemplating appropriate next steps.
16-16. 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	DHHS-CFS	**Progress** 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. A new contract for CJA funds with additional requirements is planned to go into effect in

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are spent to ensure they are addressing systemic gaps in child abuse investigations.		October 2017. The Nebraska Commission for the Protection of Children created a subcommittee to study improvements to multidisciplinary teams.
16-17. Adopt policy and procedure on checking infant sleep areas and asking about safe sleep in child welfare cases.	DHHS-CFS Private Agency: Nebraska Families Collaborative (NFC)	**Complete** In August 2017, DHHS adopted Protection and Safety Procedure #28-2017, "Mandatory Monthly Visits With Children, Parents & Out of Home Care Providers," which includes the Nebraska Safe Sleep Environment Checklist developed by Public Health and policy for workers regarding safe sleep. In 2016, NFC updated their Monthly Walkthrough Checklist, which all staff must complete on visits, to include information on the sleep environment of children under 5.
16-18. Enhance training, resources, and education available to staff, parents, and caregivers in child welfare cases on safe sleep.	DHHS-CFS Private Agency: Nebraska Families Collaborative	**Complete** In 2016, DHHS incorporated infant safe sleep into New Worker Training. An "Under Two Packet" with information about safe sleep was created with assistance from the Division of Public Health. This is distributed to all families and caregivers of children under two. In 2016, NFC incorporated Safe Sleep information into New Worker Training and a webinar has been created that is mandatory for all permanency staff. The training includes information on items that should/shouldn't be in the crib, co-sleeping, blankets, infant sleepwear, etc. NFC will require this training be completed annually by all permanency staff. NFC also distributes information safe sleep to families in an "Under Two Packet."
16-19. Revise regulations to require infant safe sleep training before granting a child care license.	DHHS-Public Health	**Progress** In June 2016, the Licensure Unit-Children's Services Licensing submitted an internal legislative proposal that would have updated

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		the current law regarding pre-service training to include safety training on sudden infant death, shaken baby syndrome and child abuse reporting. The legislative proposal did not go forward. Currently, DHHS is reviewing and developing a set of recommendations for changes in all child care regulations which will be completed in December 2017. The Licensure Unit will recommend changing the regulations to require training before a license is granted and mirror the safe sleep recommendations from the American Academy of Pediatrics including absolutely no soft materials in cribs (current programs are allowed to have a secure blanket in the crib).
16-20. Adopt federally mandated policies and procedures on mental and behavioral health care as soon as possible	DHHS-CFS	**No Further Action** See Recommendation 15-01
16-21. Enhance efforts to reduce caseworker turnover.	DHHS-CFS	**Complete** DHHS has made changes to job recruitment strategies, revisions to New Worker Training to make it more accessible and less travel-intensive to complete. In July 2017, DHHS implemented a supervisor training program to better ensure caseworkers are supported.
16-22. Adopt training and policy on supervising youth with intellectual and developmental disabilities (I/DD)	Probation	**Rejected** The OIG has reviewed all Probation training materials and policies available to it, and determined that no action to address the recommendation has been taken. Probation provided a list of reports to the OIG on its improvement efforts, no information in the reports was relevant to this recommendation.
16-23. Adopt policy on child welfare referrals and joint	Probation	**Rejected** The OIG has reviewed all Probation policies

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case management.		available to it from Probation, and determined that no action to address the recommendation has been taken. No information in reports provided by Probation was relevant to this recommendation. In 2016, Probation staff communicated to the OIG that a joint memo was being developed with DHHS and would be released that year. However, no final memo has been developed or issued.
16-24. Adopt policy on documentation and record keeping.	Probation	**Rejected** The OIG has reviewed all Probation policies available to it, and determined that no action to address the recommendation has been taken. No information in reports provided by Probation was relevant to this recommendation.
16-25. Increase internal quality assurance efforts at the state level.	Probation	**Rejected** Probation provided a list of reports to the OIG on its juvenile justice efforts, no information in the reports was relevant to this recommendation.
16-26. Adopt policy on joint case management and case planning when a youth is involved with both the child welfare and juvenile justice system.	DHHS-CFS	**Progress** DHHS has a draft policy memo developed which is being internally reviewed and prepared for adoption. The memo details how CFS staff will handle cases when Probation is also involved. DHHS reports that discussions with Probation on adopting a Memorandum of Understanding or other joint memo to better address joint cases are ongoing.
16-27. Increase training and coordination between the Division of Children and Family Services and the Division of Developmental Disabilities.	DHHS-CFS DHHS-Developmental Disabilities	**Complete** Both CFS and DD participate in the Cross Divisions Solution Team. In 2017, DD helped provide information and feedback on CFS New Worker Training and developed a powerpoint on available services for CFS staff.

OIG Recommendation	Agency or Agencies Responsible	Implementation Status
16-28. Coordinate with Juvenile Probation and improve care to youth with developmental disabilities in the juvenile justice system	DHHS - Developmental Disabilities	**Complete** DD developed and disseminated a handout for probation officers and court stakeholders providing details on the Home and Community Based Waivers available to people with disabilities, presented a training at the Nebraska Juvenile Justice Association Conference, attended weekly system collaboration meetings with Probation, and deployed clinical staff to assess youth committed to YRTCs for service eligibility.
16-29. Make the OJS Administrator a Full-time Position	DHHS-CFS	**Rejected** Although DHHS rejected the recommendation, it is complete. Mark LaBouchardiere has served as the full-time OJS administrator since Fall 2016.
16-30. Close or Appropriately Restructure Full-time Secure Care Program at YRTC-Kearney in Dickson, D5	DHHS-CFS	**Complete** In 2016, DHHS ended the full-time care program in Dickson. Currently, youth can live in Dickson for a short period of time if they have had struggles in their living unit. Each youth in Dickson has a Reintegration Plan that must be developed where the youth begins participating in normal activities as soon as they are able (example - school, group meetings). YRTC-Kearney reports that youth have not stayed in Dickson for longer than three to four weeks. These changes have not been codified in policy.
16-31. Develop Continuous Quality Improvement Process at YRTCs Led by Central Office	DHHS-CFS	**Complete** In 2017, DHHS Central Office began putting together monthly data reports on Performance-based Standards at the YRTCs. They include information on assaults, confinements, escapes, injury, restraints, misconduct, property incidents, suicidal behavior, youth seen for medical treatment, and staff-to-resident ratio.
16-32. Develop and implement a comprehensive	DHHS-CFS	**Complete**

OIG Recommendation	Agency or Agencies Responsible	Implementation Status
Strategic Staffing Plan in order to achieve appropriate staff to youth ratios while attracting and retaining qualified staff members for YRTC-Kearney		DHHS examined staffing at YRTC-Kearney, and calculated how many staff it needed to comply with PREA. Additional staff for YRTC-Kearney were included in the 2016 DHHS budget request and funded by the Legislature in 2017. DHHS reports that recruitment of staff at YRTC-Kearney has significantly improved.
16-33. Digitalize Records at YRTC-Kearney	DHHS-CFS	**Complete** In January 2017, the YRTCs began loading information on incident reports into an online portal, Salesforce. The system is now fully operational and allows facilities to review records of individual incidents as well as track specific incidents, including escapes, use of force, restraints, and seclusion.
17-01. Adopt statewide policy or protocol on what a probation officer's role is between assigning an alternative to detention and a court hearing.	Probation	**Incomplete** Probation requested modification of this recommendation, but provided no alternate suggestions. The OIG did not modify the recommendation. The OIG has reviewed all Probation policies available to it, and determined that no action to address the recommendation has been taken. Probation provided a list of reports to the OIG on its juvenile justice efforts in response to a request for updates. No information in the reports was relevant to this recommendation.
17-02. Adopt policy that specifies what restrictions are not appropriate for use as an alternative to detention.	Probation	**Incomplete** Probation requested modification of this recommendation, but provided no alternate suggestions. The OIG did not modify the recommendation. The OIG has reviewed all Probation

OIG Recommendation	Agency or Agencies Responsible	Implementation Status
		policies available to it, and determined that no action to address the recommendation has been taken. Probation provided a list of reports to the OIG on its juvenile justice efforts in response to a request for updates. No information in the reports was relevant to this recommendation.
17-03. Implement guidelines on when it is appropriate to use specific types of alternatives to detention.	Probation	**Incomplete** Probation requested modification of this recommendation, but provided no alternate suggestions. The OIG did not modify the recommendation. The OIG has reviewed all Probation policies and forms available to it, and determined that no action to address the recommendation has been taken. Probation provided a list of reports to the OIG on its juvenile justice efforts in response to a request for updates. No information in the reports was relevant to this recommendation.
17-04.Require a simple mental health screening during intake interviews and select a uniform tool for probation officers to use.	Probation	**Incomplete** Probation requested modification of this recommendation, but provided no alternate suggestions. The OIG did not modify the recommendation. The OIG has reviewed all Probation policies available to it, and determined that no action to address the recommendation has been taken. Probation provided a list of reports to the OIG on its juvenile justice efforts in response to a request for updates. No

OIG Recommendation	Agency or Agencies Responsible	Implementation Status
		information in the reports was relevant to this recommendation.
17-05. Adopt policy requiring probation officers to make and document mental health referrals if an intake interview suggests that the youth has mental health needs.	Probation	**Incomplete** Probation requested modification of this recommendation, but provided no alternate suggestions. The OIG did not modify the recommendation. The OIG has reviewed all Probation policies available to it, and determined that no action to address the recommendation has been taken. Probation provided a list of reports to the OIG on its juvenile justice efforts in response to a request for updates. No information in the reports was relevant to this recommendation.
17-06. Create an acknowledgment form for youth and parents after an alternative to detention is implemented that contains information on their rights and responsibilities.	Probation	**Incomplete** Probation requested modification of this recommendation, but provided no alternate suggestions. The OIG did not modify the recommendation. The OIG has reviewed all Probation policies and forms available to it, and determined that no action to address the recommendation has been taken. Probation provided a list of reports to the OIG on its juvenile justice efforts in response to a request for updates. No information in the reports was relevant to this recommendation.
17-07. Improve communication protocols between Probation and alternative to detention providers to ensure that key	Probation	**Incomplete** Probation requested modification of this recommendation, but provided no alternate suggestions. The OIG did not

OIG Recommendation	Agency or Agencies Responsible	Implementation Status
information on youth is appropriately passed on.		modify the recommendation. The OIG has reviewed all Probation policies available to it, and determined that no action to address the recommendation has been taken. Probation provided a list of reports to the OIG on its juvenile justice efforts in response to a request for updates. No information in the reports was relevant to this recommendation.
17-08. Collect and publish data on the length of time between alternatives to detention being assigned and a court hearing taking place.	Probation	**Incomplete** Probation requested modification of this recommendation, but provided no alternate suggestions. The OIG did not modify the recommendation. Probation provided a list of reports to the OIG on its juvenile justice efforts in response to a request for updates. No information in the reports was relevant to this recommendation.
17-09. Assess whether Probation has the authority to monitor alternatives to detention.	Probation	**Incomplete** Probation requested modification of this recommendation, but provided no alternate suggestions. The OIG did not modify the recommendation. Probation provided a list of reports to the OIG on its juvenile justice efforts in response to a request for updates. No information in the reports was relevant to this recommendation.
17-10. Adopt a policy that requires contact with mental health professionals already involved with a family when a family gives consent.	Private Agency: Owens Educational Services, Inc.	**Complete** Owens adopted a policy requiring staff to contact and stay in communication with mental health professionals whenever a

OIG Recommendation	Agency or Agencies Responsible	Implementation Status
		release is signed.
17-11. Implement training on suicide warning signs and prevention in youth.	Private Agency: Owens Educational Services, Inc.	**Complete** In April 2017, an LIMHP, PLADC Mental Health Practitioner trained staff company-wide on QPR (Question. Persuade. Refer.) training for suicide prevention. This curriculum was also added to New Hire Training.
17-12. Promulgate rules and regulations related to the Children's Residential Facilities and Placing Licensure Act as soon as possible.	DHHS-Public Health	**Incomplete** DHHS has developed a draft set of regulations with stakeholder input. These regulations have not yet been sent to the Secretary of State or set for hearing. It is unknown when and if this will occur.
17-13. Include requirements related to dispensing and monitoring medications, especially psychotropic medications, in new regulations for Residential Child-Caring Agencies.	DHHS-Public Health	**Incomplete** DHHS has included standards on dispensing medication in the draft regulations that have not yet been sent to the Secretary of State.
17-14. Adopt clear requirements on medical record-keeping and documentation in regulations.	DHHS-Public Health	**Incomplete** DHHS draft regulations include record keeping requirements for medications and specify that facilities must adopt policies on medical record-keeping. These regulations have not yet been sent to the Secretary of State.
17-15. Clarify requirements for consents for medical care, treatment, and coordination for Residential Child-Caring Agencies in regulations.	DHHS-Public Health	**Incomplete** DHHS draft regulations specify that facilities must adopt policies obtaining consent for medical treatment. These regulations have not yet been sent to the Secretary of State. DHHS is also planning to develop additional guidance for facilities on how to comply with regulations, while not adding

OIG Recommendation	Agency or Agencies Responsible	Implementation Status
		requirements to regulations themselves.
17-16. Increase coordination with the Division of Children and Family Services and Administrative Office of Probation on Residential Child-Caring Agencies.	DHHS-Public Health	**Progress** Public Health has committed to sharing information with both CFS and Probation, and, when possible, conduct joint visits of facilities with CFS. Efforts to effectively coordinate are ongoing.

Appendix B.
Office of Inspector General of Nebraska Child Welfare Act and Other Relevant Statutes

Office of Inspector General of Nebraska Child Welfare Act

43-4301

Act, how cited.

Sections 43-4301 to 43-4332 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; reports of death or serious injury; when required; 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 when the office, upon review, determines the death or serious injury did not occur by chance; 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; procedure.

(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; notice.

(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 prior to 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. Any fees associated with counsel present under this section shall not be the responsibility of the office of Inspector General of Nebraska Child Welfare.

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; summarized final report; release.

(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)(a) A summarized final report based on an investigation may be publicly released in order to bring awareness to systemic issues.

(b) Such report shall be released only:

(i) After a disclosure is made to the appropriate chairperson or chairpersons pursuant to subsection (2) of this section; and

(ii) If a determination is made by the Inspector General with the appropriate chairperson that doing so would be in the best interest of the public.

(c) If there is disagreement about whether releasing the report would be in the best interest of the public, the chairperson of the Executive Board of the Legislative Council may be asked to make the final decision.

(4) 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.

(5) 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; commission; juvenile services division; 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 beyond the entity that is the subject of 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, probation administrator, or executive 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 written response may include corrections of factual errors. 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) After the recommendations have been accepted, rejected, or modified, 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 thirty 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 and 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, 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.

43-4332

Disclosure of information by employee; personnel actions prohibited.

Any person who has authority to recommend, approve, direct, or otherwise take or affect personnel action shall not, with respect to such authority:

(1) Take personnel action against an employee because of the disclosure of information by the employee to the office which the employee reasonably believes evidences wrongdoing under the Office of Inspector General of Nebraska Child Welfare Act;

(2) Take personnel action against an employee as a reprisal for the submission of an allegation of wrongdoing under the act to the office by such employee; or

(3) Take personnel action against an employee as a reprisal for providing information or testimony pursuant to an investigation by the office.

Other Relevant Statutes

28-712.01

Alternative response demonstration projects; Review, Evaluate, and Decide Team; duties; department; duties; Inspector General's review.

(1) This section applies to alternative response demonstration projects designated under section 28-712.

(2) The Review, Evaluate, and Decide Team shall convene to review intakes pursuant to the department's rules, regulations, and policies, to evaluate the information, and to determine assignment for alternative response or traditional response. The team shall utilize consistent criteria to review the severity of the allegation of child abuse or neglect, access to the perpetrator, vulnerability of the child, family history including previous reports, parental cooperation, parental or caretaker protective factors, and other information as deemed necessary. At the conclusion of the review, the intake shall be assigned to either traditional response or alternative response. Decisions of the team shall be made by consensus. If the team cannot come to consensus, the intake shall be assigned for a traditional response.

(3) In the case of an alternative response, the department shall complete a comprehensive assessment. The department shall transfer the case being given alternative response to traditional response if the department determines that a child is unsafe. Upon completion of the comprehensive assessment, if it is determined that the child is safe, participation in services offered to the family receiving an alternative response is voluntary, the case shall not be transferred to traditional response based upon the family's failure to enroll or participate in such services, and the subject of the report shall not be entered into the central registry of child protection cases maintained pursuant to section 28-718.

(4) The department shall, by the next working day after receipt of a report of child abuse and neglect, enter into the tracking system of child protection cases maintained pursuant to section 28-715 all

reports of child abuse or neglect received under this section that are opened for alternative response and any action taken.

(5) The department shall make available to the appropriate investigating law enforcement agency, child advocacy center, and county attorney a copy of all reports relative to a case of suspected child abuse or neglect. Aggregate, nonidentifying reports of child abuse or neglect receiving an alternative response shall be made available quarterly to requesting agencies outside the department. Such alternative response data shall include, but not be limited to, the nature of the initial child abuse or neglect report, the age of the child or children, the nature of services offered, the location of the cases, the number of cases per month, and the number of alternative response cases that were transferred to traditional response. No other agency or individual except the office of Inspector General of Nebraska Child Welfare, the Public Counsel, law enforcement agency personnel, child advocacy center employees, and county attorneys shall be provided specific, identifying reports of child abuse or neglect being given alternative response. The office of Inspector General of Nebraska Child Welfare shall have access to all reports relative to cases of suspected child abuse or neglect subject to traditional response and those subject to alternative response. The department and the office shall develop procedures allowing for the Inspector General's review of cases subject to alternative response. The Inspector General shall include in the report pursuant to section 43-4331 a summary of all cases reviewed pursuant to this subsection.

43-2,108

Juvenile court; files; how kept; certain reports and records not open to inspection without order of court; exceptions.

(1) The juvenile court judge shall keep a minute book in which he or she shall enter minutes of all proceedings of the court in each case, including appearances, findings, orders, decrees, and judgments, and any evidence which he or she feels it is necessary and proper to record. Juvenile court legal records shall be deposited in files and shall include the petition, summons, notice, certificates or receipts of mailing, minutes of the court, findings, orders, decrees, judgments, and motions.

(2) Except as provided in subsections (3) and (4) of this section, the medical, psychological, psychiatric, and social welfare reports and the records of juvenile probation officers as they relate to individual proceedings in the juvenile court shall not be open to inspection, without order of the court. Such records shall be made available to a district court of this state or the District Court of the United States on the order of a judge thereof for the confidential use of such judge or his or her probation officer as to matters pending before such court but shall not be made available to parties or their counsel; and such district court records shall be made available to a county court or separate juvenile court upon request of the county judge or separate juvenile judge for the confidential use of such judge and his or her probation officer as to matters pending before such court, but shall not be made available by such judge to the parties or their counsel.

(3) As used in this section, confidential record information means all docket records, other than the pleadings, orders, decrees, and judgments; case files and records; reports and records of probation officers; and information supplied to the court of jurisdiction in such cases by any individual or any public or private institution, agency, facility, or clinic, which is compiled by, produced by, and in the possession of any court. In all cases under subdivision (3)(a) of section 43-247, access to all confidential record information in such cases shall be granted only as follows: (a) The court of jurisdiction may,

subject to applicable federal and state regulations, disseminate such confidential record information to any individual, or public or private agency, institution, facility, or clinic which is providing services directly to the juvenile and such juvenile's parents or guardian and his or her immediate family who are the subject of such record information; (b) the court of jurisdiction may disseminate such confidential record information, with the consent of persons who are subjects of such information, or by order of such court after showing of good cause, to any law enforcement agency upon such agency's specific request for such agency's exclusive use in the investigation of any protective service case or investigation of allegations under subdivision (3)(a) of section 43-247, regarding the juvenile or such juvenile's immediate family, who are the subject of such investigation; and (c) the court of jurisdiction may disseminate such confidential record information to any court, which has jurisdiction of the juvenile who is the subject of such information upon such court's request.

(4) The court shall provide copies of predispositional reports and evaluations of the juvenile to the juvenile's attorney and the county attorney or city attorney prior to any hearing in which the report or evaluation will be relied upon.

(5) In all cases under sections 43-246.01 and 43-247, the office of Inspector General of Nebraska Child Welfare may submit a written request to the probation administrator for access to the records of juvenile probation officers in a specific case. Upon a juvenile court order, the records shall be provided to the Inspector General within five days for the exclusive use in an investigation pursuant to the Office of Inspector General of Nebraska Child Welfare Act. Nothing in this subsection shall prevent the notification of death or serious injury of a juvenile to the Inspector General of Nebraska Child Welfare pursuant to section 43-4318 as soon as reasonably possible after the Office of Probation Administration learns of such death or serious injury.

(6) In all cases under sections 43-246.01 and 43-247, the juvenile court shall disseminate confidential record information to the Foster Care Review Office pursuant to the Foster Care Review Act.

(7) Nothing in subsections (3), (5), and (6) of this section shall be construed to restrict the dissemination of confidential record information between any individual or public or private agency, institute, facility, or clinic, except any such confidential record information disseminated by the court of jurisdiction pursuant to this section shall be for the exclusive and private use of those to whom it was released and shall not be disseminated further without order of such court.

(8)(a) Any records concerning a juvenile court petition filed pursuant to subdivision (3)(c) of section 43-247 shall remain confidential except as may be provided otherwise by law. Such records shall be accessible to (i) the juvenile except as provided in subdivision (b) of this subsection, (ii) the juvenile's counsel, (iii) the juvenile's parent or guardian, and (iv) persons authorized by an order of a judge or court.

(b) Upon application by the county attorney or by the director of the facility where the juvenile is placed and upon a showing of good cause therefor, a judge of the juvenile court having jurisdiction over the juvenile or of the county where the facility is located may order that the records shall not be made available to the juvenile if, in the judgment of the court, the availability of such records to the juvenile will adversely affect the juvenile's mental state and the treatment thereof.

(9) Nothing in subsection (3), (5), or (6) of this section shall be construed to restrict the immediate dissemination of a current picture and information about a child who is missing from a foster care or out-of-home placement. Such dissemination by the Office of Probation Administration shall be authorized by an order of a judge or court. Such information shall be subject to state and federal confidentiality laws and shall not include that the child is in the care, custody, or control of the Department of Health and Human Services or under the supervision of the Office of Probation Administration.

43-2,108.05

Sealing of record; court; duties; effect; inspection of records; prohibited acts; violation; contempt of court.

(1) If the court orders the record of a juvenile sealed pursuant to section 43-2,108.04, the court shall:

(a) Order that all records, including any information or other data concerning any proceedings relating to the offense, including the arrest, taking into custody, petition, complaint, indictment, information, trial, hearing, adjudication, correctional supervision, dismissal, or other disposition or sentence, be deemed never to have occurred;

(b) Send notice of the order to seal the record (i) to the Nebraska Commission on Law Enforcement and Criminal Justice, (ii) if the record includes impoundment or prohibition to obtain a license or permit pursuant to section 43-287, to the Department of Motor Vehicles, (iii) if the juvenile whose record has been ordered sealed was a ward of the state at the time the proceeding was initiated or if the Department of Health and Human Services was a party in the proceeding, to such department, and (iv) to law enforcement agencies, county attorneys, and city attorneys referenced in the court record;

(c) Order all notified under subdivision (1)(b) of this section to seal all records pertaining to the offense;

(d) If the case was transferred from district court to juvenile court or was transferred under section 43-282, send notice of the order to seal the record to the transferring court; and

(e) Explain to the juvenile what sealing the record means verbally if the juvenile is present in the court at the time the court issues the sealing order or by written notice sent by regular mail to the juvenile's last-known address if the juvenile is not present in the court at the time the court issues the sealing order.

(2) The effect of having a record sealed under section 43-2,108.04 is that thereafter no person is allowed to release any information concerning such record, except as provided by this section. After a record is sealed, the person whose record was sealed can respond to any public inquiry as if the offense resulting in such record never occurred. A government agency and any other public office or agency shall reply to any public inquiry that no information exists regarding a sealed record. Except as provided in subsection (3) of this section, an order to seal the record applies to every government agency and any other public office or agency that has a record relating to the offense, regardless of whether it receives notice of the hearing on the sealing of the record or a copy of the order. Upon the written request of a person whose record has been sealed and the presentation of a copy of such order, a government agency or any other public office or agency shall seal all records pertaining to the offense.

(3) A sealed record is accessible to law enforcement officers, county attorneys, and city attorneys in the investigation, prosecution, and sentencing of crimes, to the sentencing judge in the sentencing of

criminal defendants, to a judge making a determination whether to transfer a case to or from juvenile court, to any attorney representing the subject of the sealed record, and to the Inspector General of Nebraska Child Welfare pursuant to an investigation conducted under the Office of Inspector General of Nebraska Child Welfare Act. Inspection of records that have been ordered sealed under section 43-2,108.04 may be made by the following persons or for the following purposes:

(a) By the court or by any person allowed to inspect such records by an order of the court for good cause shown;

(b) By the court, city attorney, or county attorney for purposes of collection of any remaining parental support or obligation balances under section 43-290;

(c) By the Nebraska Probation System for purposes of juvenile intake services, for presentence and other probation investigations, and for the direct supervision of persons placed on probation and by the Department of Correctional Services, the Office of Juvenile Services, a juvenile assessment center, a criminal detention facility, a juvenile detention facility, or a staff secure juvenile facility, for an individual committed to it, placed with it, or under its care;

(d) By the Department of Health and Human Services for purposes of juvenile intake services, the preparation of case plans and reports, the preparation of evaluations, compliance with federal reporting requirements, or the supervision and protection of persons placed with the department or for licensing or certification purposes under sections 71-1901 to 71-1906.01, the Child Care Licensing Act, or the Children's Residential Facilities and Placing Licensure Act;

(e) Upon application, by the person who is the subject of the sealed record and by persons authorized by the person who is the subject of the sealed record who are named in that application;

(f) At the request of a party in a civil action that is based on a case that has a sealed record, as needed for the civil action. The party also may copy the sealed record as needed for the civil action. The sealed record shall be used solely in the civil action and is otherwise confidential and subject to this section;

(g) By persons engaged in bona fide research, with the permission of the court, only if the research results in no disclosure of the person's identity and protects the confidentiality of the sealed record; or

(h) By a law enforcement agency if a person whose record has been sealed applies for employment with the law enforcement agency.

(4) Nothing in this section prohibits the Department of Health and Human Services from releasing information from sealed records in the performance of its duties with respect to the supervision and protection of persons served by the department.

(5) In any application for employment, bonding, license, education, or other right or privilege, any appearance as a witness, or any other public inquiry, a person cannot be questioned with respect to any offense for which the record is sealed. If an inquiry is made in violation of this subsection, the person may respond as if the offense never occurred. Applications for employment shall contain specific language that states that the applicant is not obligated to disclose a sealed record. Employers shall not ask if an applicant has had a record sealed. The Department of Labor shall develop a link on the department's web site to inform employers that employers cannot ask if an applicant had a record

sealed and that an application for employment shall contain specific language that states that the applicant is not obligated to disclose a sealed record.

(6) Any person who violates this section may be held in contempt of court.

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.